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Fighting HIV/AIDS Insecurities Using A Human Rights-Based Approach: A Case Study of Zimbabwe

University of Cape Town

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And to **God** be the glory

## **ABSTRACT**

This study underscores the need to tackle the escalating HIV/AIDS pandemic in Zimbabwe through a developmental and human rights based approach. In particular it focuses on second generation rights because of their emphasis on the social welfare of individuals. Second generation rights relate to the living conditions of people in society, attempting to ensure that individuals have adequate standard of living. This is achieved through the provision of adequate food, clothing, income, housing, medical care and other essential social services. While acknowledging that behaviour change is an essential element in fighting HIV/AIDS since the virus is spread mostly through sexual contact, the study recognises that it is of limited effect if factors that constrain the ability of individuals to alter their behaviour are not addressed. The study thus recommends the upholding of second generation rights as an effective compliment to behaviour change strategies. Without mechanisms that facilitate change and build a conducive environment for such a transformation, the HIV/AIDS pandemic will continue to rage on. The research is a qualitative study conducted with a single case study. Zimbabwe is used as a case study as it provides a unique example of a country that has managed to lower its HIV/AIDS prevalence. However, it is now faced with an overwhelming challenge of increasing or at least sustaining this downward trend of the epidemic. Unfortunately, due to an economic and political melt-down the country is suffering a serious humanitarian crisis that has impoverished the community, encouraging risky sexual coping strategies and severely undermined the countries health delivery system, all which work to threaten the success achieved so far in the battle against HIV/AIDS.

## ABBREVIATIONS

ABC	Abstain, Be Faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AU	African Union
DALY	Disability Adjusted Life Year
DHS	Demography and Health Survey
GBV	Gender-based violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
MDG	Millennium Development Goals
MIPA	Meaningful Involvement of People with AIDS
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NBCS	National Behaviour Change Strategy
MSM	Men who have sex with men
NATF	National AIDS Trust Fund
NBSZ	National Blood Services of Zimbabwe
NEDPP	National Economic Development Priority Programme
NGO	Non-Governmental Organisation
OAU	Organisation of African Unity
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
TAC	Treatment Action Campaign
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFCP	Zimbabwe National Family Planning Council

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# **CHAPTER ONE**

## **PROBLEM AND METHODOLOGY**

**“HIV/AIDS is the greatest threat to mankind today, the greatest weapon of mass destruction on earth” (Collin Powell 2004:9).**

### **1.1 Introduction to the Problem**

#### ***1.1.1 Background to the problem***

HIV/AIDS has become one of the world's greatest challenges of the 21st century. As noted by Collin Powell (2004) above, it has caused wide scale loss of life globally. This Human Immunodeficiency Virus (HIV) began spreading in the late 1970s, and has become a devastating pandemic. While the epidemic has stabilised in some areas of the world, the global community is still lagging behind in its efforts to contain it (Schoepf, 2001).

The HIV/AIDS epidemic has had a devastating effect on Zimbabwe; current prevalence is estimated to be as high as 20.1% in the adult population. The disease is killing an average of 3000 people per week. This means that one in every five adults is living with the disease (UNAIDS, 2006). A parallel epidemic is prevalent among children. In 2002, Zimbabwe had one of the highest infant HIV infection rates in the world with an estimated 50 000 infants being infected annually. HIV/AIDS in Zimbabwe has resulted in the life expectancy at birth falling from 67.7 years in the early 1980s to just 34 years for women and 37 years for men; at present, this is one of the lowest life expectancy rates in the world (Chivonivoni, 2008; UNAIDS, 2006).

The global distribution of the disease is uneven with Africa bearing the greatest burden of this disease. The hardest hit areas are those south of the Sahara with Southern Africa being the epicentre of the disease. This uneven global distribution is fuelled by a plethora of social, political and economic factors. Over two-thirds (63%) of all adults and children with HIV in the world are in sub-Saharan Africa. Of these, 32% are in Southern Africa (UNAIDS, 2008). The number of people infected with HIV worldwide has increased exponentially from just a few of cases in the 1980s to close to 40 million by the end of

2006, (Abdool-Karim and Abdool-Karim, 2005). Already more than 20 million people have died of the Acquired Immune Deficiency Syndrome (AIDS). New incidences of infection are about 4.3 million (UNAIDS 2006).

The current statistics confirm a disproportionate infection rate between males and females with the prevalence of infection higher among females than males. This disproportionate prevalence is most marked in places where heterosexual contact is the dominant mode of transmission, particularly in the Caribbean and sub-Saharan Africa. However, this trend is not only being seen in endemic countries but also in low incidence countries. In Canada, the rate of new infection has been declining among men who have sex with other men (MSM) and among injecting drug users while infections from heterosexual contact have been rising steadily (Shishana, 1995). In sub-Saharan Africa, for every 10 adult men living with HIV, there are about 14 adult women who are infected. Of all the people living with HIV in this region women make up 59% of this population (UNAIDS, 2000; UNAIDS, 2006).

In Zimbabwe and elsewhere in the world the effects of HIV/AIDS are huge. The negative effects of HIV/AIDS include a decline in life expectancy, an increase in infant mortality, an increase in the Disability Adjusted Life Year (DALY)<sup>1</sup> and an increase in the number of orphans and vulnerable children. By the end of the 2007, there were more than 1.3 million orphans in Zimbabwe and the majority were AIDS orphans. Approximately 22% of the children under the age of 15 years had lost one or more parents because of the disease. At the same time, a large number of children are living with at least one seriously ill parent (UNGASS, 2008).

HIV/AIDS has also placed a huge burden on the government, as the number of people in need of medical treatment and care continues to rise. State hospitals are struggling to cope with these increasing numbers. The country is also suffering from the loss of the economically active age group, because this productive age group is dying and most of the deaths are HIV/AIDS-related. This has meant a loss of a skilled and professional workforce. This also leads to loss of household income, which in turn worsens poverty (Abdool-Karim and Abdool-Karim, 2005).

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<sup>1</sup> The measure of the number of potentially healthy years of life lost to death and disability.

The government of Zimbabwe is well aware of this huge problem. In 2003, HIV/AIDS was declared a national emergency and the then Minister of Health, Dr Parirenyatwa is quoted in the Herald (2007) as saying, “the fact that our prevalence is still a two-digit number makes us realise that we cannot afford to be complacent, rather it puts pressure on us to work even harder. Zimbabwe faces a daunting task of breaking the vicious cycle of new infections.” Much hope in the fight against HIV/AIDS in Zimbabwe comes from the fact that recent statistics have indicated a decline in the national adult prevalence rate from as high as 36% in the 1996 to 20.1% in 2006 (UNAIDS, 2006; UNGASS, 2008).

However, the current deteriorating socio-economic and political situation in Zimbabwe is feared to be eroding the gains that have been made thus far. Zimbabwe is experiencing one of the worst economic crises since the attainment of its independence in 1980. The early 1980s were characterised by rapid improvements in provision of public health, education and other social facilities with notable success. The annual economic growth rate was 3.4% and the majority of the population enjoyed a life free of poverty (Davies, 2002; Gathsheni, 2002). However, today Commentators describe the situation as the “collapse of a once vibrant political and economic system” (Thorncroft, 2006:1). The crisis has manifested itself in shortages of basic commodities, fuel, money and electricity.

Economic growth has shrunk significantly by 4% in 2001 and 5% in 2002 and still continues to drop (Lloyd, 2002). Family incomes are no longer sufficient to feed, clothe and provide other basic services such as health care and education (Kubatana.net, 2007). The crisis has also had a severe impact on the public health sector; the Ministry of Health can no longer afford to import materials to manufacture drugs, purchase and maintain equipment and infrastructure. The country is also battling to retain a skilled labour force; most professionals are migrating to other countries in search of better livelihoods. Furthermore, as a result of rising unemployment and poverty levels, fewer people are able to afford basic health care. Thus, the crisis has the potential to undermine the important successes achieved in health care and particularly in the fight against HIV/AIDS.

The increasing poverty levels in Zimbabwe are a risk factor for HIV/AIDS, as they limit the resources available for adequate protection. Some pregnant women, for example,

cannot afford to visit hospitals as frequently as is required due to financial constraints, and therefore cannot be tested in time. This has implications for the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS in cases where the mother is HIV-positive (Chivonivoni, 2008). Furthermore, due to poverty, HIV/AIDS as a threat is sidelined, because people battle for day-to-day survival. This can cause people to engage in risky behaviour such as transactional sex for financial gain; thus increasing their vulnerability to HIV/AIDS infection. This has negative effects for HIV/AIDS management programmes that focus on behaviour change, because despite the knowledge of the problem, certain socio-economic factors can make people turn a blind eye to what is right for short-term, immediate relief.

### ***1.1.2 The problem***

Evidently, knowledge does not mean a change in behaviour; sometimes other factors prevent people from taking the right action to protect themselves. This is one of the main reasons why behaviour change strategies on their own are insufficient in HIV/AIDS management. Currently, in Zimbabwe, the behaviour change strategy is the main approach that is being utilised to manage the spread of HIV/AIDS. A behaviour change approach “is a process for planning and implementing a comprehensive, strategic set of interventions and activities to change behaviours at many levels to achieve a health objective” (Academy for Educational Development, 2005:1). This approach identifies priority behaviours that need to be changed and recommends a set of behaviour change interventions. The many factors that influence behaviour change, such as increased knowledge and awareness and contextual factors (including the behaviours of family and the community), need to be taken into account. Therefore, in order for behaviour change to be effective, a range of interventions are required. These include behaviour change activities that extend beyond conventional information provision to link and coordinate communication activities with training, health systems support, product and service improvements. Social norm change and even new or improved policies should be implemented otherwise behaviour change will yield very little fruit (Academy for Educational Development, 2005).

Lee (1994) explains that an approach for mitigating the spread of HIV/AIDS that assumes that people will always make rational decisions, especially when engaging in an emotive and symbolic activity such as sex, fails to consider the temporal dimensions that characterise human action, for example, the use of here-and-now reasoning. The desire for sexual gratification or the risk of rejection, mistrust or even a loss of income or emotional support can be more important than the abstract risk of death in the future. This is why strategies for mitigating HIV/AIDS should not only focus on behaviour change, but must be expanded to include those strategies that aim at addressing the social problems that pose a constraint on behaviour change. Broadly, these types of approaches are referred to as developmental approaches. They aim at empowering individuals and eliminating social injustices that make people powerless or hopeless to change their lifestyles and situations. This further incapacitates them from taking steps that ensure their protection from infection. Developmental approaches therefore aim at encouraging a holistic and multi-layered approach to intervention that maximise the successful mitigation of the problem.

Furthermore, arguing that HIV/AIDS is best prevented using a behaviour change strategy is to imply, to a certain extent that those infected behaved in an unbecoming manner which resulted in their infection, yet this is not always the case. This moralistic perspective can also be extended to mean that the risk of infection lies in the ability or lack thereof, of people to behave in a certain way. This is, of course, a simplistic understanding of the politics of infection and prevention and it fails to explain why, for example, there is disproportionate infection between various pockets of society. It also encourages moral censor and stigmatisation and discrimination of people living with HIV/AIDS (PLWHA). Currently, trends of the epidemic in Zimbabwe and elsewhere in the world show that HIV/AIDS infection is highest among the poor and marginalised groups such as women, MSMs, prisoners, prostitutes and vulnerable children. This disproportionate infection points clearly to more than just a behavioural cause, and therefore requires more than just a behaviour change prevention strategy.

A developmental approach that focuses on strengthening the realisation of second generation rights is an example of a perspective that seeks to improve the environment that people are living in, so that they have more power to change their behaviour. Second

generation rights are the social, economic and cultural rights, which relate to the living conditions in society and are dependent on state resources and state interventions for them to be realised (Mahoney, 2007). These include the right to at least a minimum of vital necessities, such as food, healthcare, shelter and aid (Gloppen and Rakner, 1993). This is the approach that this dissertation will explore and motivate for use in a context such as Zimbabwe.

Generally behaviour change strategies place emphasis on a person's self-efficacy in achieving change. Self-efficacy is defined as a person's judgement of his/her own capabilities to organise and execute a course of action that is required to realise a change in his/her behaviour. However, self-efficacy is affected by factors in the environment that are sometimes beyond the individual's control (Bandura, 1986). Examples are poverty, a lack of knowledge and even cultural constraints. These issues are precisely what second generation rights are concerned with. An approach that emphasises the upholding of these rights would therefore compliment behaviour change strategies very well.

Such a human rights-based approach to HIV/AIDS management has not been emphasised in Zimbabwe. However, the Zimbabwean government has rightly acknowledged prevention as the backbone of its strategy to fight HIV/AIDS. Efforts must be made to limit the number of new infections because unfortunately HIV/AIDS has no cure; the disease can only be managed with the help of Antiretroviral drugs (ARVs) and ultimately HIV/AIDS leads to death. It is therefore important that a human rights-based approach, focusing on upholding second generation rights, be considered as a long-term measure.<sup>2</sup> This study therefore explores the benefits of using a developmental approach based on upholding individual human rights as a means to compliment the behaviour change strategy currently used in Zimbabwe in order to facilitate a further decline in HIV/AIDS incidence and also to consolidate the gains achieved so far in the fight against HIV/AIDS. In order to conduct a detailed analysis of HIV/AIDS management, this study is limited only to the area of preventive measures, and focuses on a case study of one country, that is, Zimbabwe. However, it is important to note here that while management of HIV/AIDS can be divided into various areas of intervention such as prevention, care and treatment,

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<sup>2</sup> See chapter three for a discussion of the tenants of human rights (section 3.1) and an outline of second generation rights (section 3.1.2).

in reality, these areas cannot be so clearly demarcated as they are in fact a continuum of inter-related components of a comprehensive response to HIV and AIDS. In addition, limiting this study to the prevention aspect of HIV/AIDS management should not be taken to imply that it is only in this area of HIV/AIDS management that a human rights approach is most applicable and useful. On the contrary, the use of a human rights-based approach is appropriate irrespective of the stage of HIV/AIDS management.

Zimbabwe is used as the case study for a variety of reasons: Zimbabwe is going through the worst political and economic crisis in its history. As its population tries to deal with their changes in fortune, they have had to use coping strategies, some of which they had never imagined that they would use. Consequently, they have experienced new patterns of behaviour that may go beyond what is deemed socially acceptable. These changes may also influence the manner in which the society deals with health issues, including their sexual health. For example, current research shows that the crisis has resulted in the booming of the sex trade as people try to make a living (PlusNews, 2007a).

### ***1.1.3 Hypothesis***

As an agency of empowerment, second generation rights can serve as a tool for fighting HIV/AIDS in Zimbabwe because they mitigate the factors that discourage behaviour change.

### ***1.1.4 Main research question***

From the above, the central research question is one that seeks to explore the usefulness of a developmental approach in HIV/AIDS prevention. The developmental approach chosen is one that aims to empower individuals through upholding their human rights, particularly their second generation rights. This approach is referred to as the human rights-based approach. In Zimbabwe, the behaviour change strategy is currently being used as the main HIV/AIDS prevention method. The human rights-based approach has been chosen because it is argued that the worsening social, political and economic environment in the country influences individual choices and impacts policy planning and implementation. This threatens to undermine the gains achieved so far in the fight against HIV/AIDS. Thus, the central research question is: **to what extent does human rights empowerment help strengthen behaviour change and mitigate the spread of HIV/AIDS?**

### ***1.1.5 Objectives of the study***

The main objectives of the study are listed below.

- To show that second generation rights are essential for the health security of individuals.
- To show that social injustice and inequalities fuel the HIV/AIDS epidemic.
- To add to the general information and knowledge about HIV/AIDS and human rights.
- To propose that preventative measures move beyond a focus on awareness to a focus on empowerment.

## **1.2 Research Methodology**

The research is a qualitative study conducted with a single case study. Qualitative research attempts to make sense of, and to interpret phenomena in terms of the meanings people bring to them (Babbie and Mouton, 2001; Dezin and Lincoln, 2000). The case study research method is used because it allows for a comprehensive and in-depth examination of a particular context within a given time period (Gerrin, 2007; Trochim, 2001).

Case studies by nature also allow for the use of more than just one means of data collection and many scholars encourage the use of multiple sources of data because this helps in establishing accuracy and validity of the information gathered. This can lead to either a collaboration of information or disparity. The disparity would then lead to a process of verification where possible. This will result in the researcher generating a much more insightful discussion on the topic.

### ***1.2.1 Methods of data collection***

Two methods of data collection are used in this research, namely a review of literature on the subject and the interviewing of key informants. The literature review is the main source of information while the key informant interviews will be useful in corroborating the findings from the review.



### ***1.2.2 Sources***

The research is primarily desk research whereby literature that relates to the main propositions of the study is reviewed. These are the issues of human rights and HIV/AIDS in Zimbabwe. The sources include books, journal articles, policy documents and reports that are relevant. Mass media sources such as newspaper articles and the internet with particular focus to websites that relate to the core issues are used. A literature review is a useful method of data collection because it allows one to look at a broad range of material and analyse multiple angles of the issues. It is also a stable source of knowledge, that is, it can be reviewed repeatedly and is not biased with regard to this particular case study (Yin 2003).

However, it is also important to remember that all written documents are inherently biased, because they are written for a specific purpose and a particular audience. This is why it is always essential to review more than just one source in order to corroborate the information gathered. This also means that in order to ensure further reliability and validity, another method of data collection can be employed to compliment the literature review.

### ***1.2.3 Interviews with key informants***

A selected number of experts<sup>3</sup> who work in the field of human rights advocacy and HIV/AIDS prevention in Zimbabwe were interviewed in order to gain a deeper understanding of the Zimbabwean context and some of the pertinent issues that they deal with on a day-to-day basis, thereby providing a practical view. Interviews reveal practical experiences that may validate the conclusions drawn from the desk research or provide an alternative view that may indicate a gap between practice and theory. An example of the consent and confidentiality agreement that they signed is included as Appendix A.

The key informant interviews were conducted as a guided conversation, because the interviewees are experts in their fields, with more in-depth knowledge about the areas being studied than what the researcher may have. Consequently, the researcher benefits if the informants are given room to provide answers to the questions the researcher has and

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<sup>3</sup> 12 experts were interviewed. Some of them preferred not to be named in the research. As a result all interview participants were referred to using a letter of the alphabet from A-L.

to provide further insights on the subject. Ideally the researcher must encourage informants to express their own opinions about the issues being discussed (Gillham, 2005; Yin, 2003).

#### ***1.2.4 Method of data analysis***

Interview data is analysed using the grounded method of data analysis, where different themes are recognised that are relevant to the theory questions as well as new emergent views that the interviews generate. The case study is useful to generate a critique of the Zimbabwean context where an argument will be developed and backed by evidence from the literature.

#### ***1.2.5 Limitations of the study***

The Human Rights Watch (2008) and Amnesty International (2008) have highlighted the worsening political situation in Zimbabwe. They point to a climate characterised by state repression and political violence. This has closed up the space for citizens to express themselves freely without fear of victimisation. They allude to the fear among Zimbabweans to discuss any issues that they think are linked to politics, and the discomfort of speaking to people they are not familiar with. This may be a limiting factor for this study, because it could affect the issue of access to interview participants.

### **1.3 Outline of the study**

As already noted in chapter one, the study interrogates the viability of using a human rights-based approach as a mechanism of strengthening behaviour change to effectively manage HIV/AIDS. The second chapter therefore presents the theoretical framework shaping the study. Behaviour change and developmental theories are discussed with particular focus on a human rights based approach. Chapter three is a literature review of material related to the research focus. Definitions, categories and key tenants of human rights are reviewed, as well as some of the insecurities caused by HIV/AIDS. Chapter four focuses on the case study, providing a socio-political and economic background of Zimbabwe and the impact this has on health and HIV/AIDS. It also outlines the governments' response to the epidemic and the strategies being used to prevent further spread of HIV/AIDS. Chapter five provide a discussion of the use of a human rights based approach, highlighting the challenges and the merits of using this kind of approach. Chapter six is the conclusion, tying up all the main arguments of the study.

## **THEORETICAL FRAMEWORK**

This chapter outlines the theories that inform this study. Behaviour change theories are the backbone of the current response to HIV/AIDS management in Zimbabwe. They shape policy and practice as well as the general understanding of the epidemic. Developmental approaches are discussed as an alternative framework through which HIV/AIDS can be understood and managed.

### **2.1 Behaviour change approaches**

Initial responses to the HIV/AIDS epidemic centred on finding the source of the disease, focusing on whom and what was responsible for its spread. There was a tendency to blame those already infected, this blame fell on the deviant groups and the marginalised populations such as gay men, sex workers, the uneducated, the poor and foreigners, because these people were initially recognised as the vectors for the spread of HIV/AIDS. However, with time, it became clearer that everyone was a risk with some more vulnerable than others. Responses then shifted from blaming victims to public awareness of the disease. People needed to be educated about the disease, how it could be spread, prevented and managed. The underlying assumption was that if people were informed then they would change their behaviour and stop taking risks and prevent new infections. This behaviour change approach is still emphasised today, and has seen the birth of campaigns that encourage safer sex behaviour through abstaining, being faithful and wearing condoms (Welbourn, 2002).

This approach is informed by behavioural change theories which assume, that behaviour change is possible, given specific scenarios. Use of these theories in healthcare is not unique to the management of HIV/AIDS; it has been used for management of addictive substances and also in physiology. The most widely used behaviour change theories in HIV/AIDS management are, the health belief model, the theory of reasoned action and theory of planned behaviour and the social cognitive theory. While all of these theories help explain how behaviour change occurs, some of them explain why it occurs and some even attempt to explain how the changed behaviour can be sustained.

### ***2.1.1 The social cognitive theory***

The social cognitive theory argues that behaviour change can occur when a person learns a new behavioural aspect that they feel is desirable. People learn to change by observing others and through participating in the act personally (Bandura, 1996; Grizzel, 2007). In order for change to occur, a person must believe in their potential to perform the behaviour and must value the outcome or consequence that they are expecting. While this theory acknowledges that behaviour change is determined by environmental, personal and behavioural elements that interact in a triadic and reciprocal manner, the focus is on self-efficacy. Self-efficacy can be defined as the “individuals impression of their ability to change and is thought to be predictive of the amount of effort the individual will expend in initiating and maintaining the behaviour change” (Grizzel, 2007:1).

### ***2.1.2 Theory of reasoned action***

This theory is based on the premise that humans are rational beings and that they can control the behaviour they seek to change (Family Health International, 2004). The theory contends that intention and a person’s attitude are important factors in influencing behaviour. These are determined by the beliefs a person has about the outcome of the behaviour, value of these outcomes and the influence of the opinions of those around the individual. Behaviour thus reflects a rational calculation of gains and losses (Grizzel, 2007; Kempe, 1999).

This theory was later modified to the theory of planned action. This modification was intended to accommodate situations where the person is not in total control of all the factors leading to the change in behaviour. These factors include the control over resources, and the skills necessary to perform the behaviour. As a result, the probability of actual change in behaviour is seen to be proportional to the amount of control an individual possesses over the behaviour and the strength of the individual’s intention in changing the behaviour (Family Health International, 2004; Grizzel, 2008).

### ***2.1.3 Health belief model***

This theory argues that individuals will change their health-related behaviour according to the perceived severity of the threat to their wellbeing, the perceived risk or

vulnerability to the illness, the benefits of taking preventative action, and the barriers to taking that action (Grizzel, 2007). Change occurs in response to various cues to action, such as physical symptoms of a disease and media publicity (Family Health International, 2004). Essentially the argument is that once a person knows that they are at risk of contracting a disease or that their life is under some form of disease threat, they will then take positive steps to reduce this risk or to eradicate the threat completely. Again, the emphasis is placed on the will power of the individual to realise that there is a threat and to take steps to protect themselves.

## **2.2 Limitations of behaviour change approaches**

While most behaviour change models recognise the importance of environmental, social and economic factors in shaping behaviour, they do not place much emphasis on these factors, but rather tend to be “conceptually committed to a linear and cognitive model of human action where knowledge and belief determine choice and agency” (Edstrom, 2002:114). They focus on self-efficacy or the power of an individual to act. This places the burden of change and blame for failure to change on the individual. These individualistic theories blame AIDS on sexual lifestyles, and leave out environmental factors, encouraging a discourse that suggests that those with HIV/AIDS can be blamed for their situation.

This not only reinforces the assumption that behaviour is the only important variable in HIV infection, but also shifts attention from the fact that for some people, it is extremely difficult to navigate social and economic contexts that predispose them to infection. Such contexts include unequal power relations, poverty and a lack of information among other factors (Kempe, 1999). Furthermore, there are in fact a range of factors which affect risk to infection that are not directly related to a person’s behaviour. These factors could include social norms and values, legal rights, discrimination with regard to age, sex, ethnicity, gender or racial categories (Edstrom et al., 2002).

It is a fact though, that HIV/AIDS prevention should encourage behaviour change that reduces the chances of sexual transmission and mother-to-child transmission. However, such a focus is limited if it just ends as an awareness raising venture and fails to change

the norms regarding how people are able to respond to specific situations, and foster an empowering and enabling environment that supports individuals and communities in sustaining behaviour change (Edstrom et al., 2002).

Behaviour change strategies also fail to take into account the importance of certain religious and cultural factors that influence identity construction and social acceptance. In some cultures people are identified and gain social status through marriage and through parenthood. To a certain extent, this shapes what it means to be a 'man' or a 'woman' and influence one's self esteem. Some people will therefore behave in ways that safeguard these values even when this is at the expense of their wellbeing. For example, people engage in unprotected sex to have a baby or practice polygamy in order to prove fertility or to get a male child (Vambe, 2003; Welbourn 2002).

Another important limitation of the behaviour change approach is that it fails to recognise that the behaviour of one person can cause illness in another person. This is particularly important for sexually transmitted diseases where one party may be able to change their own behaviour but cannot change or control that of their intimate partner. The faithfulness of one partner is very insignificant if the other is indulging in unprotected sex (Family Health International, 2004; Welbourn, 2002). A faithful wife for example is as much at risk of infection as one who is promiscuous if her husband is unfaithful. Graca Machel quoted in Achmat (2006:6) argues that:

“The existing methods to prevent infection are failing many women. Asking women to simply abstain, be faithful or use condoms is not practical. Nor is it enough, especially when UNAIDS reports that 75% of new infections are acquired from a spouse or a regular partner ... Marriage or being in what a woman thinks is a monogamous, faithful relationship is sadly one of the biggest HIV risk factors for many young African women.”

Behaviour change models under-play the fact that people do not always make rational choices but may act out of habit, emotion or impulse. Individuals may even make here-and-now decisions choosing short-term gain over long-term gain. With sexually transmitted diseases such as HIV/AIDS, people do not, for example, consider the impact of their sexual encounter on their life expectancy but rather focus on immediate needs

such as satisfying a sexual need or ensuring emotional, social and economic security (Kempe, 1999). In fact, behaviour change approaches give an illusion of choice and agency yet in reality, choice is constrained or absent and consequently people fail to change even if they know that they should (Welbourn, 2002).

These approaches do not take into consideration that there are some individuals who are in denial of their vulnerability and possible risk to infection. Such people are not likely to change their behaviour because they do not see the need to do so. Furthermore, as noted by Cundari (2007:1) “a perplexing phenomenon exists among individuals who outwardly preach safe sex but who themselves do not practice”. This points to the fact that while public awareness about the epidemic is high, this is not influencing people’s behaviour in their private lives but actually creates cognitive dissonance whereby people know how they should be behaving, but act hypocritically because they are unable to change (Cundari, 2007; Welbourn, 2002).

In addition, it is difficult for people to change pre-established behaviours. Behaviour change is rarely a discrete single process that happens easily and immediately. “Most people find themselves ‘recycling’ through the stages of change several times ‘relapsing’ before the change becomes truly established” (Zimmerman, Olsen and Bosworth, 2000:1). For a terminal disease, such as HIV/AIDS, relapse may mean infection.

Lastly, behaviour change theories, for the most part, encourage the development of HIV/AIDS policy that is coercive and pragmatic. Policy is coercive in advocating external action but not punitive action targeting PLWHA, which does not address the social needs and plight of the afflicted and affected. This is combined with pragmatic education and prevention, which emphasises awareness-raising and falls short of empowering people (Kempe, 1999).

## **2.3 Developmental approaches**

Viewing HIV/AIDS from a developmental point of view encourages one to look at the situation from a holistic perspective, where socio-economic factors are interrogated in relation to their fuelling of the pandemic. An empowerment-based approach that focuses

on using a human rights-based framework is suggested as the best practice in this dissertation.

### ***2.3.1 An empowerment-based approach***

This approach recognises that HIV/AIDS has “to do with the risks that each one of us take, our personal ability to make choices about those risks – and [that] some of us have far more choices than others” (Welbourn, 2002:101). Emphasising behaviour change in situations where people feel powerless to change encourages despair and helplessness, but when individuals are empowered to tackle socio-economic problems, they are better placed to make informed decisions about their lives. It recognises that even if awareness is raised about a disease, without redress of the complexities of gender, other social inequalities and power imbalances, behaviour change is not possible nor sustainable (Welbourn, 2002). Edstrom *et al.* (2002:114) explain that “information, awareness raising and targeted education clearly support behaviour change but often require a range of other empowering and enabling environmental changes in order to support individuals and communities in achieving them”.

Societal beliefs and norms can, as an example, work to undermine behaviour change. For example, a behaviour change approach that encourages people to change from engaging in unprotected sex to using condoms without any attempt to understand the ‘politics’ of condom use is unlikely to succeed. Such issues as the availability of condoms, the ability for both partners to negotiate condom use, the negative attitudes towards condoms or the desire to procreate are misunderstood.

### ***2.3.2 A human rights-based approach***

Contemporary studies and efforts in the fight against HIV/AIDS have recognised the importance of upholding human rights if the battle against the disease is going to be won. World leaders at a United Nations (UN) high level meeting held in 2006 re-affirmed that the full realisation of all human rights and fundamental freedoms for all is an essential element in the worlds response to the HIV/AIDS pandemic (Jurgens and Cohen, 2007). This is because it is becoming increasingly noticeable that when it comes to the spread of HIV/AIDS, a poor respect for human rights facilitates its spread and worsens its impact in the lives of those whose rights have been disrespected. HIV/AIDS not only thrives



amidst prevalent inequalities but also intensifies these inequalities (UNAIDS, 2005). This has led to an empowerment approach to HIV/AIDS management that can be termed a human rights-based approach.

While acknowledging that there is no single definition of a human rights-based approach, Roseman and Gruskin (2004:15) argue that a human rights-based approach implies, “being guided by the needs and rights of the community while simultaneously empowering those same communities to broaden their participation and strengthen their relationship with law, policy makers and partner organisations.” A human rights-based approach must include the full participation of PLWHA and vulnerable groups to address factors such as gender, power relations, religion, sexual orientation and race. These factors influence how people are protected from marginalisation, discrimination, and the extent to which they are able to make and carry out free and informed decisions about their lives.

Global Care UK, an organisation that explicitly uses a rights-based approach in their programmes for managing HIV/AIDS, defines the approach as being “guided by a human rights focus on respecting human dignity, achieving fairness in opportunities and equal treatment for all and strengthening the ability of local communities to access resources and services” (Global Care, 2008). The human rights-based approach is grounded in the upholding of all individual rights; it is not just focused on the political and civil rights of people. The approach is especially concerned with the second generation rights that seek to ensure the socio-economic empowerment of the population. Unless socio-economic factors are addressed, HIV/AIDS will continue to rage on and even reverse the hard won development gains achieved so far (PACT, 1999). Poverty, for example, makes it difficult for people to worry about safe sex when getting food for one’s family is the number one priority. In developing countries, a large numbers of the people are living in poverty and everyday decisions centre on immediate survival (An-Na’im, 2002). AIDS is not categorised an immediate problem as much as hunger and starvation are.

This approach therefore focuses on removing socio-economic inequalities that predispose certain community members to disease vulnerability. The most affected groups are women, children and poor people. These groups lack the necessary resources and the

political power to make their voices heard. Social inequality could be in the form of religious and cultural norms that strip people of authority over their own lives, while economic inequalities include insufficient money to acquire health-enhancing resources. It is such issues that human rights are concerned with and which a rights-based approach seeks to address. Advocating for rights is an attempt to provide a level playing ground where everyone has equal opportunities to meet the basic minimum for a good existence. Rights also seek redress the inequalities that exist in society by ensuring that everyone is treated equally regardless of any peculiarity in their being or way of life.

UNAIDS has the long-term goal to develop human rights-based approaches to HIV/AIDS management. This is because they recognise that “a rights based approach can help mitigate the impact of HIV/AIDS as it allows for a creation of a supportive policy, legal, social and cultural environment in which people infected or affected are able to participate in, contribute to and enjoy economic social cultural and political development (Roseman and Gruskin, 2004).

## **2.4 HIV/AIDS: A human rights issue?**

The links between human rights and health are numerous and complex in nature. Human rights empower individuals and communities to respond effectively to reduce the spread of the disease and to lessen the impact on those already infected (Ogechi, 2006). Abusing rights can have serious, negative consequences for the health of individuals. The lack of human rights protection fuels the spread of HIV/AIDS in four main ways.

Firstly, the absence of rights puts individuals at greater risk of infection with HIV/AIDS. HIV spreads with frightening efficiency due to sexual violence, lack of access to preventative resources such as condoms, lack of harm reduction measures for drug users and lack of information. Furthermore, when the civil and political rights of individual are not protected, the ability of society to mobilise and to fight the disease is curtailed. For example, the suppression of the freedom of expression or the right to participate may make it difficult for civil society and individuals to respond to the plight of the marginal groups, such as sex workers who may be criminalised by the state (Ogechi, 2006).

In addition when social and cultural prescriptions of masculinity and femininity control and determine what men and women know, how they communicate with each other and how they behave within their relationships, this significantly affects not only men's and women's sexual behaviours and attitudes, but also their respective access to services and information and their ability to cope when ill. In most traditional societies, women's rights are disregarded and women are perceived as subordinate, dependent and passive. Their ideal virtues include virginity, motherhood, obedience and ignorance especially about sexuality.

In contradiction, men are aggressive, dominant, independent and invincible. Their key virtues are strength, courage, knowledge and virility. As a result, women are unable to assess with accuracy the risks they face and take steps to reduce them. Cultural norms and expectations can also place women in a vulnerable position where HIV infection is concerned. For example, in cultures where a man or a woman's worth is defined by his/her ability to produce children and the use of condoms is discouraged, risk of HIV infection is therefore very high (Abdool-Karim and Abdool-Karim, 2005).

Secondly, the risk of infection and its impact also travels along the fault lines of human rights violation. These violations include discrimination against marginalised groups, such as women, sex, workers, IDUs, MSMs, prisoners and children, particularly the female child (Jurgens and Cohen, 2007; UNAIDS, 2008). Patterson and London (2002:964) argue, "In each society those people who before the arrival of HIV/AIDS were marginalized stigmatized and discriminated against became over time those at the greatest risk of HIV infection".

Human rights violations also lead to the stigmatisation of the persons who are at highest risk of infection and this result in such persons hiding away from the public eye, which limits their access to information and treatment (The Human Right Watch, 2008). For example, sex workers, IDUs and MSMs are viewed as deviants and criminals in some countries; consequently they tend to hide from the public eye in order to avoid imprisonment, moral censor and other forms of recriminations. This in turn interferes with their ability to freely access information and resources that they need to protect themselves from infection.

Furthermore, in policy planning and creation of programmes to impact HIV/AIDS, these groups and their particular needs are ignored. In fact, some laws and regulations can actually be responsible for their further discrimination and victimisation. The UNAIDS (2008) explains, “Several countries still have policies that interfere with the accessibility and effectiveness of HIV related measures for prevention and care. For example laws criminalizing consensual sex between men and laws prohibiting condoms for prisoners” (UNAIDS, 2008:1).

Thirdly, HIV/AIDS intensifies human rights abuses. With stigmatised diseases, such as HIV/AIDS, being infected with or affected by the disease can lead to further violation of one’s rights through discrimination and stigmatisation.

“HIV frequently begets human rights violations such as further discrimination and violence [and this is why] over the past decade the critical need for strengthening human rights to effectively respond to the epidemic and deal with its effects has become evermore clear. Protecting human rights and promoting public health are mutually reinforcing” (UNAIDS, 2008:1)

Ill people, their family members or even objects associated with those who are HIV-positive are shunned by society. For example, children with ill parents can be shunned by others at school. Discrimination is also witnessed through the loss of jobs or even social isolation experienced by some PLWHA. Others have been murdered because of their status.

Lastly, the absence of human rights has also been recognised to increase the impact of the disease on those who are already infected (Ogechi, 2006). The Democracy Consolidated Programme (2007) notes how people can be barred from working, accessing insurance and health benefits once their HIV-positive status is known. This intensifies the effect of the disease in their lives because they can no longer look after themselves and their families, access health services and eat a healthy diet, among other problems. This dehumanises the person and affects their psychosocial well-being. Clearly, a lack of attention to human rights can have serious health consequences. Upholding individual rights makes people less vulnerable to disease; conversely, abusing individual rights makes people more vulnerable to disease.

## **2.5 Limitations of a human rights-based approach**

A human rights approach on its own is not sufficient in tackling the HIV/AIDS pandemic because it also has its shortcomings. The ideal practice would be to combine this approach with the behaviour change approaches that are currently in use. Some of the problems of using a human rights based approach include the fact that human rights arguments alone are of limited use. There is a need to combine them with mass mobilisation including rights awareness campaigns. In the context of HIV/AIDS, it also means organising those who are directly or indirectly affected to stand up and take action on the violations of the human rights that they suffer (Democracy Consolidated Program, 2007).

Moreover, international human rights laws are rather general, and therefore do not offer particular guidance. For example, they do not offer specific guidance on IDUs, other than the general principles of non-discrimination and obligations to control disease. Provisions for enforcement of these rights are also generally weak, especially when dealing with the enforcement of second generation rights (Patterson and London, 2002).

To add on, most human rights discussions about HIV/AIDS focus on the issue of non-discrimination of PLWHA. While this is important, it has tended to overshadow other important rights issues. This focus is primarily due to the dominance of western preoccupations with civil and political rights, which protect citizens from state interference (Patterson and London, 2002). Such a narrow conception of rights is limited for many developed countries because it fails to engage with the full range of social, political and cultural factors that underlie the vulnerability to HIV.

Lastly while most countries speak the language of rights, they neglect to practice them. Unfortunately, on paper, there is a lot of motivation for human rights in the response to HIV/AIDS, yet in practice there have been few efforts made to implement national programmes that ensure legal and human rights protections for people living with and affected by, or vulnerable to HIV/AIDS (Cohen and Jurgens, 2007).

## **2.6 An integrated approach to HIV/AIDS management**

Due to the limitations of both Behaviour change strategies and human rights-based approaches that have been outlined above, this dissertation proposes the use of an integrated approach to disease management, where behaviour change strategies are combined with human rights-based approaches in order to ensure long-term and short-term management of the disease. Jacobs (2008) acknowledges the benefit of an integrated approach that combines behavioural prevention programmes with strategies that focus on empowerment, participation and social change. This is in recognition of the need to empower communities to tackle the underlying issues of discrimination, gender inequality, dominant traditions, religion, legal issues, poverty, unemployment and insufficient incomes all of which drive the HIV epidemic (Edstrom et al., 2002).

## **CHAPTER THREE**

### **HUMAN RIGHTS AND HIV/AIDS**

This chapter provides a literature review of the main concepts useful for this study. It provides a conceptual background for the study by providing definitions of key terms and listing characteristics and categories of human rights. After which the insecurities caused by HIV/AIDS at an individual and national level are discussed.

#### **3.1 Human rights**

Human rights are a legal instrument that protects individuals and groups against actions that interfere with their fundamental freedoms and dignity. They are principally concerned with the relationships between the individuals and the state. The state has the obligation to respect, protect and fulfil the rights of the individual (Egendorf, 2003). In essence, human rights are a set of internationally, agreed norms, principles and standards that operate through national, regional and international institutions and programmes (Roseman, 2003).

These rights include “the right to life; liberty; personal security and safety; inequality and non-discrimination; a fair trial; family; privacy; participation; work; social security; an adequate standard of living; health; education and culture. They also include freedom from torture and other forms of cruel, inhumane or degrading treatment and freedom of religion, expression, association and assembly and demonstration” (Dersso, 2008:4). Human rights, are “those rights which belong to all people regardless of national origin, race, culture, age, sex or anything else” (Dersso, 2008:4).

Human rights are based on three foundational instruments, which are encompassed in the Bill of Rights. The Bill of Rights is a collective term for what is regarded as the nucleus of the international instruments in the field of human rights. It contains the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (1966) and the International Covenant on Economic, Social and Cultural Rights (1966). The two covenant documents are regarded as legally binding for state parties that have signed them and ratified them, while the Universal Declaration of Human Rights is

viewed as binding to all states and not only those that explicitly recognise it (Gloppen and Rakner, 1993). However, despite human rights gaining prominence in international politics, there still is a disjuncture between rhetoric and practice. A number of states that have ratified them continue to be ambivalent about upholding them.

### ***3.1.1 The key tenants of human rights***

The main characteristics of human rights are that they are universal, inalienable, indivisible, interdependent and inabrogable entitlements. They are universal in that they are applicable to everyone indiscriminately the world over. It is this universality of human rights that provides a basis for setting standards that apply to everyone in all societies and to every government and hence the prospect of universal justice (Campbell, 2006). Human rights are interdependent and indivisible in that one cannot pick or choose rights and the best way to secure them is to work at them simultaneously. This does not mean that all human rights will always be secured to the same degree, but rather, that in any given situation, each right should be advanced while advancing or at least not undermining another (Okafar, 2007). They are entitlements in the sense that any human being can demand them, and they cannot be withdrawn by anyone, forfeited, renounced or suspended without a justifiable legal basis. They are also inabrogable because they cannot be given up voluntarily, nor can they be traded for other privileges (Ife, 2001).

### ***3.1.2 Categories of human rights***

The two covenants on human rights, namely the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights categorise rights into two main groups. The Civil and Political rights can be further divided into three categories, which are personal rights, civil or liberal rights, and political freedoms. Economic, Social and Cultural Rights can be sub-divided into social and economic rights, cultural or national rights and solidarity rights (Gloppen and Rakner, 1993).

Rights were divided into two covenants for logical and pragmatic reasons, because each of the two categories is subject to different procedures of implementation. However, these categories have lead to arguments about the relative status and importance of these



two covenants and each set of rights. While, most governments recognise that social and economic rights are just as important as political and civil rights and have taken steps to ensure that these rights are broadly delivered; in practise, these two sets of rights are not treated as equal.

Economic and social rights continue to be second place to political and civil rights. Western countries are the most supportive of this view, while Non-Governmental Organisations (NGOs), especially in Asia, place more emphasis on the importance of the second set of rights (Bernasconi, 2007; Egendorf, 2003). The way the wording of the two covenants was done is argued to give political and civil rights a higher standing compared to economic and social rights. The Covenant on Civil and Political Rights “orders an immediate duty to states to comply with the regulation of the covenant”. While the Covenant on Economic, Social and Cultural Rights “only urges that states should take steps with the view to progressively achieve to the maximum of the available resources within the nation and through international assistance” (Gloppen and Rakner, 1993:3).

Those who do not recognise social and economic rights see them as undermining individual freedoms and distorting free market conditions by allowing government interventions in the economy. This is because governments have to take positive action to ensure the protection of social and economic rights. While those in favour of the legal status of social and economic rights “argue that the right to life is illusory without the protection of the means by which life can be lived” (Bernasconi, 2007:141). By promoting social and economic rights, states are in fact doing the work that they should already be doing, that is to provide the necessary infrastructure for a decent standard of living, regulating economic investment and providing education, healthcare and other necessary services without discrimination (Bernasconi, 2007).

UN resolution 32/130 in 1977 was adopted as an attempt to end this debate. The resolution stated that the two categories of human rights are inter-related and inseparable and that no category takes precedence over the other. This was later re-affirmed in another general assembly in 1989. Through Resolution 44/129 which states that “all human rights and fundamental freedoms are indivisible and interrelated and that the promotion and protection of one category of rights should never exempt or excuse states

from the protection and promotion of the other” Lawson (1991: 951) quoted in Gloppen and Rakner (1993:4).

Another way to categorise rights is through a chronological history of human rights. This shows that they have developed in waves or generations that show, to an extent, the relative importance of certain issues at certain points in history. However, the emergence of new generations of rights does not indicate that the older generations of rights has been over-taken in importance by the new ones. Rather it indicates a response to new issues and a deepened awareness of older ones (Gloppen and Rakner, 1993; Ife, 2001; Mahoney, 2007). Therefore, the UDHR contains three distinct generations of rights.

First generations rights found as Article 2-15 of UDHR are the oldest set of rights argued to have originated in the 18th Century and are sometimes referred to as the classic liberties of Locke (Mahoney, 2007). First generation rights are usually discussed with the discourse of natural rights. These being the rights that human beings possess or inherit as part of the natural order (Ife, 2001). These rights are mainly the civil and political rights concerned with ensuring individual liberty and how the state and other human beings can infringe upon this liberty. Protection of these rights is guaranteed through constitutional provisions by the state, and hence legal recourse when they have been abused (Gloppen and Rakner, 1993). These rights are individually based and concerned with the fundamental freedoms that are important for the “effective and fair organisations of democracy and civil society... [Examples include] the right to vote, freedom of speech, rights to free trial, privacy and self expression” (Ife, 2001:25). First generation rights are also defined as negative rights because of the emphasis on protection and expectation that other individuals or states must refrain from interference (Gloppen and Rakner, 1993).

The distinction between first and second generation rights can be paralleled to the division of the two covenants on human rights. Second generation rights are argued to be the socialist contribution to international human rights because they owe much of their existence to the work of the labour movement and some religious groups (Gloppen and Rakner, 1993). Second generation rights are the social, economic and cultural rights. These relate to the living conditions in society and are dependent on state resources and state interventions for them to be realised (Mahoney, 2007).

Second generation rights attempt to ensure each individual has an adequate standard of living sufficient for his or her health and wellbeing. This includes enough food, clothing, housing, medical care and other necessary social services (Reichert, 2007). These rights are positive because “they imply a much more active and positive role for the state. Rather than simply protecting rights, the state is required to take a stronger role in actually ensuring that these rights are realised through various social provisions” (Ife, 2001:26). The realisation of these rights is therefore dependent on the political, social and economic wellbeing of the particular state as well as the international pressure that this state is under (Mahoney, 2007). Regrettably,

“despite the fact that there are a range of conventions and human rights instruments that seek to cover second generation rights, they are not generally as effective, as it is difficult to establish guilt and apply sanctions... and so legal processes designed to prevent abuse are not as readily applicable” (Ife, 2001:26).

For example, it is difficult for a political leader to be taken to court for inadequate educational systems as compared to being charged for genocide (Ife, 2001).

Lastly, third generation rights are the collective rights, also referred to as solidarity rights and recognised as ‘rights of the 21st century’. These rights are the contribution to international rights norms by third world countries (Gloppen and Rakner, 1993). These rights are collective, belonging to a community, population, society or nation rather than being readily applicable to an individual even though the individual will benefit from their realisation (Ife, 2001:26). These rights include the right to economic development and growth, the right to live in a harmonious and cohesive society and the right to clean water, among others.

Third generation rights are also argued to have emerged as a response to the threats to life, liberty and security due to the technological advances of recent years. Mahoney (2007:97) posits that “increasing urgency about the quality of air as well as of the earth and its waters has multiplied anxieties to bring human environmental interest and rights to the forefront of global concerns” and hence third generation rights. The realisation of these solidarity rights requires inter-governmental cooperation on world issues such as environmental protection and economic development (Reichert, 2007).

The inclusion of third generation rights in international treaties is still very much in the preliminary stages and so too is the development of legal and constitutional mechanisms to guarantee their protection. Consequently, for most people particularly in the west, these rights are not recognised as rights, and this is due in part to a dominance of a liberal understanding of human rights. Third generation rights are subject to further scepticism, because there is no consensus on whether development should be viewed as a right or whether it is a process that will end with the realisation of universally accepted goals (Gloppen and Rakner, 1993; Ife, 2001).

## **3.2 HIV/AIDS**

HIV is a virus, which passes from one person to another mainly through sexual contact and causes AIDS. HIV and AIDS are preventable but unfortunately not curable. Antiretroviral (ARV) therapies just help manage HIV and AIDS as a chronic disease, which will eventually kill its victim (Achmat, 2006).

### ***3.2.1 The insecurities caused by HIV/AIDS***

HIV/AIDS is now recognised as a human security threat by both governments and international organisations. This is a result of the devastation HIV/AIDS has brought to all sectors of the society. In June 2001, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) recognised that:

“AIDS constitutes a global emergency that challenges human life, dignity and rights, undermines socioeconomic development around the globe. The impacts occur at all levels of society [that is] national, community, family and individual” (UNGASS, 2008:1).

Kofi Annan (2000) at a UN Security Council meeting acknowledged that HIV/AIDS was in fact causing much more destruction in Southern Africa than warfare itself. It therefore threatens the welfare of nations, this led to the adoption of UN Resolution 1308, which declares HIV/AIDS “a risk to stability and security”, putting a health issue on the security agenda for the first time (Stearns, 2006:37).

HIV/AIDS kills indiscriminately, regardless of gender, age, sex, class or belief and has disabled millions the world over limiting the quality and standard of their lives. Abdool-Karim and Abdool-Karim (2005:37) liken this disease to “a whirlwind sweeping everything before it, as millions become infected, fall ill and die.” HIV/AIDS, like most chronic illnesses, does not just affect the infected individual but affects the lifestyle of those around them, as they nurse the patient and at times even watch them die.

#### **3.2.1.1 Individual and household insecurity**

HIV/AIDS is a huge threat to the welfare of individuals because the disease not only attacks the body but the mental and emotional state of the individual. The cost of HIV/AIDS on the individual is profound; they are severely ill and cannot take care of themselves or work. It disrupts their life in all aspects. This has a huge effect on their morale and self worth. Prolonged illness also affects parenting skills as the parent is too ill to take charge of the household. Role reversal can occur with children ending up taking care of the sick parent (Beegle et al., 2006).

HIV/AIDS is also a stigmatised disease and this is something that both the sick individual and those close to them have to deal with. HIV/AIDS-related stigma is identified as one of the major impediments in the fight to control the spread of HIV and AIDS. Stigmatisation leads to a low self worth, depression, fear and shame. It is also cited as one of the reasons why HIV-positive people are not willing to disclose their HIV status, seek treatment and adhere to their treatment regimes. Stigma is also the primary cause of social isolation, shame and loss of emotional and financial support suffered by children who are orphaned because of HIV/AIDS (Stein, 2003). It is important to address HIV/AIDS-related stigma and discrimination because it helps “to curb the further spread of HIV and mitigate the devastating impact of the epidemic...and to promote social justice and equity” (Accord, 2004:10-11).

To make matters worse, those close to the patient sometimes also suffer stigmatisation and discrimination from the rest of society. This is ‘courtesy stigma’, the stigma extended to family members, carers and even objects owned or touched by PLWHA’s. Thus, the caregivers, friends, children, spouses, siblings and parents of PLWHA may suffer loss of

friends and harassment. Courtesy stigma has been attributed to the lack of adequate knowledge about the disease by the public and even caregivers (Rivers and Aggleton, 2000).

HIV/AIDS has also been recognised as leading to the increase in household expenditure. Mortality and morbidity due to HIV/AIDS can affect household consumption through significant costs incurred from medical expenses and special diets for the patient and this is worsened by the fact that the illness is usually very prolonged. Funeral expenses also take a huge amount of the household income and at times death occurs when most of the resources have been used up in an effort to heal the patient. Funeral expenses cover coffins, clothes, food and transport costs (Arrehag et al., 2006; Beegle et al., 2006).

Resultant impoverishment is acutely felt because HIV/AIDS disproportionately affects men and women in their prime age (15 to 50 years) who are the breadwinners in their families. This prime age group is most affected because it is the age group most likely to engage in unprotected sex for child bearing (Beegle et al., 2006). The loss of the breadwinner translates into the loss of family income and labour. This loss of income occurs at a time when it is needed the most. Further income and labour loss could be experienced if another member of the household has to give up their job to nurse the sick (Arrehag et al., 2006).

Further impoverishment occurs through the depletion of savings. This can lead to liquidation of assets to raise an income. Unfortunately these assets are sold at a paltry price, because of the desperation for quick cash. Both productive and non-productive assets are sold and this further impoverishes the household. For example, in agrarian households, livestock maybe sold despite it being a source of power when ploughing the fields or a source of milk to supplement their diets (Arrehag et al., 2006; Ruggles et al., 2001).

Impoverished families are also known to borrow to meet the financial costs imposed by illness. PLWHA end up getting loans from friends, family, micro-finance lenders and insurance. Usually the poor do not have collateral and so borrow from informal credit lenders who charge exorbitant interest rates creating a cycle of borrowing and worsened

poverty. Female-headed households generally experience difficulties in accessing loans and this leaves them more vulnerable to abuse (Arrehag et al., 2006).

The lack of a reliable income could lead those most vulnerable to engage in anti-social and risky behaviour. Some of these behaviours include petty crimes, such as theft, prostitution and transactional sex. Transactional sex can result in HIV infection. Factors such as poverty, poor immune systems, war, and migration, poor access to health and education and lack of social power render people susceptible HIV/AIDS. The poor experience HIV/AIDS differently from the rich, while it is mainly a poor person's disease, the rich have better access to the resources needed to manage the infection should they acquire it (Beegle et al., 2006; Rivers and Aggleton, 2000).

The feminisation of HIV/AIDS has also been widely discussed. AIDS is a female tragedy, because women are biologically and socially more susceptible to HIV infection. The burden of care also falls on the women, as they have to juggle their labour time between domestic work, care work and income-generating work. They care for those in the household who are ill and yet sometimes fail to get care when they themselves are ill (Parker et al., 2000). Children, particularly the female child, are sometimes taken out of school or drop out to care for sick family members. This naturally has long-term implications on the quality of life that these girls will have. Without an education, they are caught in a vice-grip of continual poverty (Coombe, 2006; Stein, 2003).

Women also fall victim to accusations of being the vectors of the disease (Lindegger and Maxwell, 2005; Vambe, 2003). Furthermore, many women lose their property upon the death of their spouse. As a coping mechanism, they may remarry or participate in wife inheritance practices in order to access new forms of socio-economic security, even though both of these fuel the spread of HIV/AIDS. Orphans and other vulnerable children (OVCs) are also known to enter into early marriages as a way of escaping from their problems (Arrehag et al., 2006).

Insecurities resulting from HIV/AIDS are evident in the lives of OVCs. Their fate is summed up by the Population Development Review (2001:21) that claims:

“AIDS is declining entire generations of young productive adults, while leaving behind a huge cohort of children without parental and adequate support, vulnerable to exploitation and lacking educational and livelihood opportunities.”

A huge burden is also placed on extended families who are sometimes too impoverished themselves to look after chronically ill relatives and their children. This can lead to the formation of child-headed households. In other instances, these children are separated from the family they know in order to live with the new caregivers. All of which have psychosocial consequences on the children (Arrehag et al., 2006; Stein, 2003). OVCs can also become victims of abuse and exploitation. The abuse could be financial in the sense that the children are used as a source of cheap labour. Their inheritance is sometimes appropriated by relatives who are supposed to take care of them or by caregivers who take care of them as a means of getting money to care for their own households (Stein, 2003).

The psychosocial impact of HIV/AIDS on the orphaned children has generally been neglected in intervention programmes with more focus on provision of material needs. Yet, this is a key area because of the nature of the disease. The prolonged illness makes children parentless well before their parents are pronounced dead. These children also have to witness their parents succumb to a debilitating illness which may even cause mental instability and loss of bodily functions. For some of these children, this is experienced twice as both parents are infected. After which, the child has to cope with death and life after the death of the parents. In the end these “children are left wounded by emotional loss and by the fact that these emotional wounds are ignored and hidden so that the rest of the community does not have to see them or face their consequences” (Stein, 2003:7).

Furthermore, the illness and death of the parents result in poverty and hardships for these children leading to nutritional deficiency diseases (Arrehag et al., 2006; Parker et al., 2000). Also of concern is the fact that the OVCs are stereotyped and stigmatised as delinquents, deviants and criminals because of the lack of parental care and discipline.



This focus shifts the emphasis from the problems that the children face, by portraying them as the problem and a threat to the security of the greater society (Stein, 2003).

#### **3.2.1.2 National insecurity**

The HIV/AIDS pandemic has compromised national security by negatively impacting the economic and political welfare of states.

“Nations in Africa are faced with their greatest challenge ever, as their productive age groups succumb to the pandemic... HIV/AIDS poses a threat to the very fabric of the society, and is increasingly recognised as a risk factor for social and political instability” (Abdool-Karim and Abdool-Karim, 2005:37).

At the economic level, HIV/AIDS is increasing the cost of doing business. For example, HIV/AIDS can be taken as a payroll tax because companies are paying for the cost of treatment for their employees through expensive health and insurance benefits. In addition, these companies also suffer the cost of death and funeral benefits when the ill workers or their family members eventually die. This raises the cost of the employee to the company thereby eating away at their profits (Ruggles et al., 2001).

Mortality and morbidity of employees and their family members causes a high absenteeism rate in workplaces and this result in a higher workload for those that remain at work. Personal illness, funeral attendance and caring for the sick are the three major causes of absenteeism that relate to HIV/AIDS. Generally, if absenteeism is prolonged, productivity is affected but an immediate effect is a low morale of the employees. Illness and death of fellow employees are major reasons for a low morale (Arrehag et al., 2006; Ruggles et al., 2001).

Furthermore, companies have to continually recruit and train new workers to take up the vacant posts left open due to long illness or death. The high attrition of workers means that organisations are losing labour, skill and expertise and this translates into a loss of money through decreased productivity and quality of the goods and services (Arrehag et al., 2006). Mattes and Manning (2003:12) explain that “an increasingly small number of workers will be at their jobs long enough to develop specialised skills, expertise and

professionalism that is needed for their job". The overall impact of HIV/AIDS on business is an increasing labour cost accompanied by a decline in labour productivity, which makes it more expensive for companies to do business (Parker et al., 2000).

The death of the working population also causes national insecurity by undermining the tax revenue base of the government. The formally employed are the taxable population, when they fall ill and die, then the government loses some of the revenue. This is a double-edged sword in the sense that the government needs this revenue much more than ever because of the current burden placed by HIV/AIDS on the overall government budget (Mattes and Manning, 2003). The loss of tax revenue also affects the potential for the public sector to cope with the pandemic, particularly the health and welfare sectors. HIV/AIDS threatens to consume large chunks of healthcare budgets of most countries in Southern Africa. Hospitals are no longer able to cope with the increasing number of patients due to shortages of staff, medicine and beds and this situation is worsened by the fact that HIV/AIDS patients tend to stay in hospitals for much longer periods (Mattes and Manning, 2003; Shishana, 2003).

Furthermore, as the prevalence of HIV/AIDS rises at a national level, the presence of opportunistic infection increases among the population. This is a major drawback for public health as infectious diseases that had been managed effectively are now re-emerging (Arrehag et al., 2006). The impact of HIV/AIDS in the public sector is also noticed in the loss of essential skills. Governments battle to replace teachers, nurses, doctors and army personnel among others who too are not immune to the disease. HIV/AIDS is crippling the ability of nations to be self-sustaining and to protect and propagate themselves (Coombe, 2000; Mattes and Manning, 2003). The informal economy has also suffered the AIDS scourge. Informal traders have fallen prey to the disease and this has led to loss of services as the informal business close down and disappear when their owners become too ill to work or have died (Arrehag et al., 2006).

HIV/AIDS also threatens the existence of democracy. The 15 to 49 year age group, which forms the majority of the voting population and makes up most of the political representatives, is the hardest hit by HIV/AIDS. This age group is dying or is too ill to work, and this influences the sustainability of current electoral models because

HIV/AIDS lowers public involvement in political and electoral processes. For the electorate, ill people are the least likely to travel to go and vote. The high death also increases the possibility of ghost voters as updating the voter's roll is out paced by the frequency of death. The low voter turnout usually attributed to apathy may in fact be a result of AIDS death and illness (Chirambo, 2004; Mattes and Manning, 2003).

From the discussion above, the importance of upholding second generation rights to help manage HIV/AIDS becomes clearer, because these rights are concerned with the social wellbeing of society; they seek to address most of the insecurities that HIV/AIDS causes for the individual and the community.

## **CHAPTER FOUR**

### **CASE STUDY: ZIMBABWE**

This chapter provides a background to the current socio-political and economic context of present day Zimbabwe. This is important for this study in that it gives an insight into some of the potential risks of HIV/AIDS infection that the population of Zimbabwe face. It also outlines some of the ways in which the government of Zimbabwe has responded to the HIV/AIDS crisis and this is mainly through the behaviour change approach.

#### **4.1 Background on Zimbabwe**

Zimbabwe, which has an estimated population of 12 236 805 and a population growth rate of 0.62% is currently facing a complex mix of natural, political and socio-economic problems that can worsen the HIV/AIDS crisis. This is because sexual behaviour is highly liable and prone to change whenever people are presented with new and unfamiliar pressures and situations (Caballo and Solby, 2001). The severe droughts, political upheavals, human rights violations, rising poverty and lack of foreign investment and support have contributed to the worst humanitarian crisis the country has ever faced and has caused significant deterioration in social services (UNICEF, 2008; UNDP, 2008).

##### ***4.1.1 The political situation***

After gaining independence in 1980, Zimbabwe had a thriving economy which grew by over 20% in the first 10 years (Gabus and Khumalo-Sakuthukwa, 2003). However, in the last 8 years the country has suffered from political turmoil, which has depleted the economy. In the period between 2000 to 2006, real Gross Domestic Product (GDP) fell by 33.5% in cumulative terms while economic growth declined to -4.6% in 2006 (UNGASS, 2008). From around 1999, President Robert Mugabe and the ruling party have focused policy mainly on land redistribution in order to regain land from the non-indigenous white farmers. While the motivation was noble, the results were mostly disastrous. In the end, agricultural productivity was disrupted leading to acute food

shortages, unemployment and wide scale migration (Avert, 2008a). Since then, various other policies have worsened the plight of the ordinary Zimbabwean.

Generally, the President's policies are seen as geared for expedience and short-term gain aimed at maintaining power at the expense of the country's well being (Rodriguez, 2008). For example, in 2005, the government launched Operation 'Murambatsvina' or 'Restore Order' and this resulted in the demolition of informal homes and businesses with tenants being forcibly removed without alternative dwellings. More than 700 000 people ended up homeless, unemployed and lacking essential social services such as clean water, sanitation, healthcare and schools for their children (Avert, 2008a; UNICEF, 2007).

The government has also been rather hostile to foreign NGOs, interfering with their operations and intimidating their staff. At one point, the government threatened to pass a law that would prevent these NGOs from working on human rights and would give the government authority to interfere with their operations. (Avert, 2008a:3). One interview<sup>4</sup> participant lamented on the challenges of "working in a paralysed environment with a government suspicious about help". Mugabe also "has a well found reputation as an iron fisted dictator" and this, together with accusations of mismanagement of donor funds, has significantly impacted the country's relations with donor agencies and donor countries. Avert (2008b) notes how the Global Fund for AIDS, TB and Malaria stopped funding Zimbabwe because the government did not distribute \$7.3 million that was meant for HIV/AIDS programmes in the country. International AID from the World Bank was also suspended due to poor loan management (PlusNews, 2008c).

Furthermore, some of the country's laws have been cited as unfavourable for effective protection of all citizens regardless of their sex, gender and age. Studies in Family Planning (1993) point out that law can be responsible for the systematic neglect or abuse of certain groups within the country. Some laws can prevent people from taking appropriate measures to protect themselves, for example, laws prohibiting the issuing of contraceptives to young adolescents limit their chances of protecting themselves from STIs and unwanted pregnancies.

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<sup>4</sup> Interview A

Other laws may seem neutral, yet in fact fail to protect or be inadequate in the way they protect these groups of people. For example, in Zimbabwe, women's rights are still largely accorded to them within the confines of customary law "Section 23 (3) (b) of the Zimbabwean Constitution protects Zimbabwean citizens from discrimination but allows for discrimination on the ground of 'customary law' in any cases involving Africans" Human Rights Watch Report (2006:35). Customary law fails to protect widows from loss of property upon death of a spouse and has prevented female-headed households from acquiring land through land redistribution programmes (Human Rights Watch, 2002).

Widespread reports of violence characterise the political landscape in Zimbabwe. This violence intensified during the run up to the March 31<sup>st</sup> 2008 elections with leaders and supporters of the opposition parties being beaten up, maimed, killed and tortured with some of them disappearing (Human Rights Watch, 2008). Prominent opposition leaders, including the presidents of the two main opposition parties, have fallen victim to this violence; they were beaten up while detained in police cells. The opposition parties are also alleged to have retaliated, escalating the violence. Civic society dealing with human rights, in particular, has also been targeted in the violence. The government is accused of using excessive force in dealing with protest and unauthorised gatherings. Heavily armed riot police and youth militia have been used to control any dissent (Human Rights Watch, 2008; New Zimbabwe, 2008; "Opposition arrested and beaten", 2007).

#### **4.1.1.1 Effect of the political situation on health and HIV/AIDS**

In the health sector, some major international donors have stopped funding programmes in Zimbabwe, because they do not want to "prop up Mugabe's regime". In 2004, the World Bank gave other Southern African countries money averaging about \$150 million for HIV programmes, but gave Zimbabwe only \$4 million (Meldrum, 2008:1060). This is despite Zimbabwe being in the top five countries with the highest HIV/AIDS burden in the world. It is also estimated that in 2005, Zambia received around US \$187 for every HIV-positive person, but Zimbabwe only received about US \$4 (Avert, 2008b; Fleshman, 2006).

The Ministry of Health and Child Welfare without any external assistance, cannot cope with the pandemic. "While the national budget allocation for health increased in both

nominal and real terms in the period 2002 to 2007, the increase was not sufficient to match the demand on the health sector placed by the HIV and AIDS pandemic” (ZNASP, 2006:20). Currently, international support comes from a number of donor agents, mostly from UNAIDS and the rest of the ‘UN family’ (Kates and Wilson, 2005). The low donor funding has affected most HIV/AIDS preventative services, treatment and care services such as the roll out of ARVs.

Programmes, such as the Operation Murambatsvina and the land redistribution, resulted in the loss of employment for large numbers of people leading some to anti-social and risky behaviours, such as stealing and prostitution for survival. Prostitution puts people at a higher risk of HIV infection. These two programmes also resulted in displacement and migration of the population which disrupted ARV and Home-Based HIV/AIDS programmes. Close to 80 000 adults living with HIV/AIDS were displaced by Operation Murambatsvina (Avert, 2008a). In 2005, a national survey of 5407 households of PLWHA was conducted by Action Aid on the effects of Operation Murambatsvina. It found that, 61% of PLWHA lost their access to home-based care, 46% to ARVs and 45% to treatment of opportunistic infections (Kasambala, 2006).

#### ***4.1.2 The social environment***

Zimbabwe now has a 70% unemployment rate and growing rates of poverty, with close to 80% of the population of Zimbabwe living below the government’s own poverty line (Kapp, 2004). Poverty in this instance being defined as:

“a multidimensional phenomenon, encompassing the inability to satisfy basic needs, lack of control over resources, inadequate access to water, sanitation, and health and education services, vulnerability to violence and crime, and lack of a political voice. In addition to the direct effect resulting from poor access to service” (Green et al., 2001:586).

There is an acute shortage of food and more than 4 million people are in need of food aid. The increased poverty levels have led to widespread malnutrition and it is estimated that 600 000 children require therapeutic feeding (Meldrum, 2008). Acute malnutrition has resulted in a 29.4% stunting in children under the age of five, the worst since 1988 (UNICEF, 2007). Malnutrition coupled with overcrowding has caused an increase in TB

infection (IRIN, 2008). Starvation has also started to kill. Dr Pedro quoted by Rodriguez (2008:10) comments, “I am seeing people for the first time literally starving to death...” In desperation, people are now eating wild berries and herbs. Some of which have turned out to be poisonous with fatal results (PlusNews, 2008b). Poverty can also push people into situations that jeopardise their sexual health, such as sex work and other forms of transactional sex (Butler, 2004).

The government has been failing to treat water supply due to lack of foreign currency and this has meant that a large bulk of the population has no access to safe water for drinking and domestic use. Towns and cities experience frequent water and power cuts and the deteriorating sanitation is bringing back cholera outbreaks. In addition, most of the urban city councils can no longer afford to remove refuse from the communities leading to piling rubbish heaps, and raw sewage is flowing in some parts of the urban areas (PlusNews, 2008a). This has dire consequences when it comes to the spread of disease. Already, a cholera epidemic is being battled in areas such as Chitungwiza, Bulawayo, Beitbridge and has spread to all other urban areas. This outbreak threatens to engulf the whole country. Neighbouring countries have started to experience an over spill of this problem, as the sick are now crossing the border to seek medical help (The Zimbabwean, 2008; UNICEF, 2007).

Another noteworthy social issue is the issue of homosexuality in Zimbabwe. The Human Rights Forum (2001) argues that the Zimbabwean society is predominantly homophobic with a President who openly castigates homosexuality and common law criminalises homosexuality. Zimbabweans have failed to embrace homosexuality and regard it as un-African (Vambe, 2003). Marginalised populations, such as homosexuals, are highly vulnerable to infection and are the ones whose rights are frequently violated. As a result, they continue to be sidelined in policy implementation and resource allocation, thus remaining vulnerable (Jurgens and Cohen, 2007; UNAIDS, 2008). None of the NGOs interviewed had any programmes specifically targeting homosexuals, despite almost all of the human rights organisations admitting that homosexuals were extremely vulnerable to serious human rights abuses<sup>5</sup>.

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<sup>5</sup> Interviews H, I, J and K



The education sector has also deteriorated due to reduced public expenditure and a high rate of attrition by trained personnel due to low wages and a lack of motivation. Infrastructure in government institutions is now run down and is not being replaced or repaired due to a lack of funds and foreign currency. Schools are also experiencing lower enrolments and declining pass rates because learners are either ill or too hungry to come to school. Some learners have to nurse sick family members or their parents can no longer afford to send them to school (UNICEF, 2007).

Another valuable form of education was the informal education passed down from generation to generation; this included sex education. In the local Zimbabwean culture, the maternal aunt and the paternal uncle were the traditional givers of sexual information to boys and girls. These traditional imparters of knowledge are now on the decline resulting in parents and teachers having to take a more positive role in imparting the values and responsibilities that they want for their children, especially in view of the threats of HIV/AIDS (Roger, 2000). However, the unravelling of families because of urbanisation, migration and other factors has resulted in young people being separated from relatives who traditionally played key roles in their sexual education (Stally, 2003).

Cultural and religious factors also sanction the behaviour of people in Zimbabwe because a lot of religions exercise a great deal of control over the sexual choices of their members. For example, Christians do not encourage premarital and extramarital sexual activity. Even within the Christian community, various churches have control over the sexual welfare of their followers. For example, the Roman Catholic Church does not encourage the use of contraceptives and this is seen by some as an infringement on the sexual rights of these people.

Marriage is also seen as desirable within both cultural and religious circles. In the cultural setting, marriage is not confined to monogamy (Keslby, 2000) and some religions also allow polygamy. For example, some of the Apostolic churches (Mapostori) in Zimbabwe encourage young women and girls to marry older men and enter into polygamous relationships (Stally, 2003). Cultural expectations and pressures relating to the respectability of marriage and the need for financial stability both work to undermine the ability of women to go against their husband and family's desires (Chingandu, n.d.;

Chivonivoni et al., 2008). The decency of motherhood, fertility and marriage in heterosexual unions also influences women's desires to have children and stay married. In some instances, women jeopardise personal safety for social security (Vambe, 2003; Keslby, 2000).

Traditional belief is generally patriarchal and this is sanctioned legally through customary law provisions within the Zimbabwean Constitution. Women are therefore socialised to take subordinate roles to their male counterparts. Lack of power impedes women's ability to protect their sexual health both with long-term regular partners and with more short-term informal sexual encounters.

“The subordinate positions [of women] with respect to men circumscribe their options. Few are able to practise safe sex and some do not feel able to open dialogue with sexual partners on the subject” (Schoepf, 1992:276).

Others who have attempted to speak out have experienced rejection and retaliation (McFadden, 2003).

Furthermore, these imbalances operate in the background of a double standard that gives men greater sexual autonomy and rights of self-determination than women enjoy. At the personal level, social, economic and demographic characteristics control the degree to which individuals have access to and use of sexual health services. At the relationship level, the type of relationship (for example marriage, cohabitation, commercial or casual) and the communication between partners also has an effect on the power relation and use of services (Blanc, 2001). “Due to lack of control over sexual matters, very young girls, married women and prostitutes alike run a high risk of being infected with STIs including AIDS.” Their human right to health existence is endangered because culture does not allow them to decide what to do with their own bodies (Human Rights Watch, 2006:35).

While the power in heterosexual relationships is usually tipped in favour of the male partner, some recent studies indicate that this power can in fact be dangerous to men themselves, when power is rooted in patriarchy that encourages a hegemonic masculinity characterised by male aggression, promiscuity, dominance and virility. As men try to live up to these ideals of the ‘real men’, they can at times engage in risky behaviour such as multiple partners that put them and their partners at risk (Lindegger and Maxwell, 2005).

In Zimbabwe, cultural prescriptions prevent the open discussion about sex and sexuality. This is particularly catastrophic when addressing a sexually driven epidemic such as HIV/AIDS. Maposhere in Keslby (2000:1427) explains this issue in relation to Zimbabwean women. She argues that, “even though people have sex, nobody talks about it; sex is not discussed in relations and in society as a whole. If a woman is open about sexual issues, she gets a label, maybe as a prostitute”. In the Zimbabwean society, discussions around sexuality are taboo; this is not a subject for open discussion.

In addition, the cultural practice common in Zimbabwe of a man paying a bride price (roora) for his wife is argued to facilitate the spread of HIV/AIDS and compromise the reproductive health of women by treating women as commodities. While this payment traditionally strengthens family ties between in-laws, it also has a sinister side in that a woman may lose control over her life. Domestic violence is sometimes justified by this cultural tradition, in the heat of domestic arguments, husbands often tell their wives that they must obey them and can be beaten up because they have been paid for. As the bride price amounts rise, this problem also escalates. The rising cost of living and inflation has led to a rise in bride price and it is now common for it to be charged in foreign currency (Wendo, 2004).

Traditionally, the payment of ‘roora’ did not give the husbands the right to beat up their wives. Women’s families protected their daughters against marital abuse. But when marriage payments skyrocketed, a woman’s family may be more concerned with ensuring that the marriage lasts so that they do not have to repay ‘roora’. They may fail to protect their daughter from abuse by a wealthy son-in-law (Zimbabwe Human Rights Forum, 2006). Women in Zimbabwe still lack the capacity to take control over their sexual lives and to demand protection both within and outside the institution of marriage.

Violence against women impacts women’s sexual and reproductive health, particularly the transmission of HIV (WHO, 2004). Many women’s organisations report that domestic violence is pervasive in Zimbabwe. On March 2001, UNICEF issued a press release condemning the increasing tide of violence against women in Zimbabwe and called for the enactment of the Domestic Violence Bill. According to UNICEF, a combination of an inflexible approach to cultural and traditional practices and an

economic downturn has disrupted acceptable gender roles, as men become economically emasculated through unemployed and unable to provide for their families they tend to enforce their power through violence (Zimbabwe Human Rights, Forum 2006). This has meant that gender-based violence has become frighteningly common in Zimbabwe.

In the past, the Sexual Offences Act legislated against domestic violence, but the general view is that this is a family and not a court matter. This is clear in the attitudes of relatives, government officials and parts of the judiciary (Kasambala, 2006). The Prevention of Domestic Violence Bill of 2007, which was drafted more than 10 years ago, was only brought before Parliament in July 2006 and only gazetted in 2007, indicating an ambivalence and lack of urgency on the part of authorities in dealing with domestic violence (Zimbabwe Human Rights Forum, 2006; UNGASS, 2008).

#### **4.1.2.1 Effect of the social environment on health and HIV/AIDS**

The high levels of poverty and acute shortages are driving the issues of HIV/AIDS into the background of people's problems. Zimbabweans are caught up in the challenges of trying to put food on the table and are not likely to be worrying about HIV/AIDS prevention. Poor HIV-positive mothers, for example, will feed their babies with breast milk despite the risk, if they cannot afford the transport fees to go and get the free formula milk (Chivonivoni et al., 2008; Chingandu, n.d.). While financially, insecure women are likely to stay in abusive relationships for economic security (Chingandu, n.d.). People will do whatever is necessary to survive.

Dangerous survival strategies such as "poaching, prostitution and theft" are also on the increase. PlusNews (2007a:1) reports that Zambia is experiencing an influx of Zimbabweans who are engaged in "activities frowned upon by the community" The increasing numbers of Zimbabwean sex workers on the streets of Zambia is testing the patience of the government. This places people at high risk to infection with HIV/AIDS and other sexually transmitted diseases. In the interviews<sup>6</sup> conducted, almost all the research participants felt that as the battle for survival in Zimbabwe intensifies, more and

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<sup>6</sup> Interview A, B, C, F, G, H, I, J and K

more people are becoming daring and reckless in the survival strategies that they chose endangering not only themselves but others as well.

High rates of malnutrition result in compromised immune systems, which are susceptible to all kinds of diseases including HIV/AIDS (Kapp, 2004). Starvation also speeds up the effects of HIV/AIDS. With proper nutrition and medical care, HIV-positive people will take up to 10 years to develop full-blown AIDS, but for those with low immune systems, it can be just a matter of months (Rodriguez, 2008). All the research participants highlighted starvation as a major problem. One interviewee<sup>7</sup> explained that, at present, the public is not interested in any programme that does not provide some immediate relief to their food crisis.

Furthermore, most of the ARV cocktails require that a person take them after a meal. Some Zimbabweans are now taking these on an empty stomach, as they do not have food or in some cases access to or cash to buy food. This has side effects on the patient and has meant failure of others to adhere to the treatment regimes. This puts them at risk of developing virulent strains of HIV (PlusNews, 2008b).

The deterioration in education standards has long-term implications for HIV/AIDS management. There is growing evidence that good sexual health is strongly associated with school attendance, linked to the fact that school provides opportunities to obtain literacy and decision-making skills, and boosts the chance for economic self-sufficiency later. More specifically, educational institutions have programmes that provide sexuality schooling have been found to be helpful in advancing sexual health by delaying the start of sexual activity, increasing the use of contraception and decreasing early child bearing (Butler, 2004).

Lastly, many women in Zimbabwe do not have the right to sexual and reproductive autonomy. They are placed in insubordinate positions to the men and this “creates a highly unfavourable environment for preventing HIV infection especially when major prevention strategies recommended are abstinence, mutual fidelity or use of male condom none of which are in the control of the women” (Mutangadura, 2000:2).

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<sup>7</sup> Interview D

#### ***4.1.3 The economic situation***

Zimbabwe is also facing a huge economic crisis. The government is struggling with a wide variety of economic problems that include an unsustainable fiscal deficit, an overvalued exchange rate and soaring inflation. By May 2006, inflation rates had reached 1193% and are currently estimated to be over 230 000 00% and still rising (Keller, 2008; Human Rights Watch, 2006). Due to these hyperinflationary circumstances, a huge proportion of the population is living below the food datum line which is the minimum food resources needed to prevent malnutrition (Mpofu and Nyahoda, 2008).

Due to inflation, prices of food and other basic commodities continue to rise and more and more people are becoming impoverished. Shops are empty and those with commodities are selling them in foreign currency at prices out of reach for many. By and large, the population cannot access their monies from local banks because daily maximum withdrawal limits are not enough to sustain an individual for a day. In November 2008, these limits were Z \$500 000 (a little under US \$2). Transport to the city from surrounding residential areas costs, on average, Z \$300 000 per single trip, thus a single trip to and from the city costs more than the daily withdrawal allowed (PlusNews, 2008b). The country also suffers acute shortages of fuel, with some garages no longer operational while others are now selling fuel in foreign currency. Shortages of fuel and spare parts have meant that some essential health services such as ambulances, mobile outreach programmes and referrals have been grounded (Kapp, 2004).

##### **4.1.3.1 Effect of the economic situation on health and HIV/AIDS**

The food shortages and unemployment have caused wide spread migration of Zimbabweans in search of better survival and economic opportunities. From the interviews<sup>8</sup>, it became clear that NGOs were losing valuable staff as a result of migration and this migration was also disrupting their programmes because their clients were becoming highly mobile. Migration has also resulted in the worst human resources attrition in all sectors of the economy as those with brains and brawn are leaving the country in thousands. The health sector is one of the hardest hit by this out migration (UNGASS, 2008). Zimbabwe in 2007 had only “800 registered doctors giving a patient doctor ratio of about 1 doctor for 12 000 patients” (Meldrum, 2007: 1059). This has

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<sup>8</sup> Interview C and F

severely compromised the quality of service and has meant that the available personnel are working under extreme pressure and strenuous conditions (USAID, 2006).

The hyperinflation and shortage in foreign currency have made it extremely difficult for the Ministry of Health and Child Welfare (MoHCW) to import essential drugs or afford raw materials to manufacture drugs as well as purchase equipment and spare parts. Most government hospitals are barely functional with two of the country's major referral hospitals having to close as a result. This is worsened by the fact that the current political crisis has led to loss of international aid, among other things. All this has undermined the quality of patient care and treatment as well as affected policy and programme implementation. At one time, Zimbabwe had some of the best health indicators in Africa, but these have deteriorated over the last 10 years leading to the "collapse of a once vibrant health care system" (Thorncroft, 2006:1). The current socio-economic and political situation threatens to undermine some important gains in health care (UNAIDS, 2008).

The hyper-inflationary economy has also thrown the public health sector into disarray, because it is continually increasing medical fees to keep up with inflation. At the same time, it is expected that fewer and fewer people will be able to afford basic medical care because of the current rates of unemployment and rising cost of living (Thorncroft, 2006). For example, in 2005, a caesarean section cost the equivalent of US \$400, which was not even within the reach of the average professional woman who earned on average US \$250 per month. This meant that for HIV-positive women, the choice of a caesarean birth as a means of reducing the chances of perinatal infection were limited (Chivonivoni et al., 2008).

While ARVs are given freely in government treatment programmes and by most NGOs working in this field, not everyone needing them is on these programmes. For those who have to purchase them, they cost more than three times the average formal wage earned by civil servants, placing them out of the reach of many. Currently the cost of ARVs is estimated to be Z \$20 million (about US \$50). Also, some of the medication for opportunistic infections that the patients have to take in conjunction with the ARVs is not

provided freely and cannot be acquired easily, especially when one does not have any foreign currency (PlusNews, 2008b).

The shortage of foreign currency has also threatened the operations of some NGOs. Reports from IRIN (2008) indicate that in April 2008, a large number of NGOs were facing collapse after the central bank failed to release money that they needed for their operations and to pay their workers. Private companies have also been hard hit by the economic environment. Companies are fighting to keep afloat in very difficult and uncertain times. As a result, a number of companies are reported to be making the decision to stop HIV/AIDS programmes for their HIV-positive staff. IRIN (2008:1) notes "...because of the economic meltdown, companies are feeling the pinch, business is declining, profits are shrinking and the cost of running the HIV/AIDS programmes is high".

There is also growing evidence that both migrants and refugees are more susceptible to HIV/AIDS than people who do not move (Caballo and Solby, 2001). The loss of familial ties, separation from partner and loss of social networks as well as the vulnerable position of refugees in new countries create opportunities for risky sexual behaviour as people seek financial, social and emotional support and acceptance.

In addition, formal sector employment has declined extensively and this means that fewer people have basic medical aid. The decline in formal employment also has serious consequences for HIV/AIDS management in Zimbabwe. A substantial amount of the government revenue for fighting HIV/AIDS comes from the 3% AIDS levy taxed on every taxable income. The reduction of formal employment means a reduction in the taxable population and consequently a reduction in the government's revenue from the AIDS levy (UNGASS, 2008).

## **4.2 Trends of the HIV/AIDS epidemic in Zimbabwe**

The first case of AIDS was reported in 1985 and at that time it is estimated that around 10% of the population was infected. This figure rose to about 29% by 1997 (Avert, 2008a). The prevalence is argued to have reached its peak in 2004 with 34% of women



attending ante-natal clinics testing HIV-positive<sup>9</sup> (Garbus and Khumalo-Sakutukwa, 2003; UNGASS, 2008; ZNASP, 2006). By the end of 2005, an estimated 1.6 million people were living with HIV/AIDS, making it the fourth highest HIV/AIDS prevalence rate in the world. Women account for more than half of the adults living with AIDS, in 2007, they were estimated to be carrying 58% of the disease burden (Kates and Wilson, 2008). Young women aged 15 to 29 years are the most vulnerable to infection (UNGASS, 2008 and ZNASP, 2006). Zimbabwe also has one of the world's highest perinatal infections (Chivonivoni et al., 2008).

However, current statistics point to a decline in HIV/AIDS prevalence. In 2007, national HIV estimates indicated an adult prevalence of 15.6% in the 15 to 49 year age group (UNGASS, 2008). For women, in general, the prevalence in 2004 was at 25.8% and by the end of 2006 it had fallen to 17.7 (UNGASS, 2008; ZNASP, 2006). This makes Zimbabwe the only country in Southern Africa that has experienced a decline in the prevalence of HIV/AIDS. Reports of a fall in HIV prevalence were recorded in 2004, 2006 and most recently in 2008. However, many experts did not believe that these figures were correct (Garbus and Khumalo-Sakutukwa, 2003).

The high rates of migration, the unstable political environment and the collapse of the health delivery system have caused critics to doubt the accuracy of the statistics emanating from Zimbabwe (Avert, 2008a). Despite this disbelief of previous years, most observers are now acknowledging that the prevalence is dropping. The United Nations (UN) and World Health Organisation (WHO) have since accepted the recent figures (Avert, 2008a, PlusNews, 2007b; Fleshmen, 2006). The challenge that Zimbabwe faces now is to build on these achievements. The decline is attributed to education and prevention programmes that lead to positive behaviour change such as late sexual debut among youth, fewer sexual partners and increased condom use (Fleshman, 2006).

The main mode of HIV/AIDS transmission is heterosexual contact, this accounts for 92% of all transmissions, while perinatal transmission is 7% and all other forms make up just 1% (ZNASP, 2006). Consequently, prevention strategies have centred on trying to reduce sexual transmission and PMTCT. This has meant large scale education on safe sex,

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<sup>9</sup> ante-natal clinic data are currently used in Zimbabwe as the main sentinel surveillance of HIV/AIDS

widespread condom use and the encouragement to take HIV tests. In particular, pregnant women are also encouraged to take the HIV/AIDS test so that they can take the necessary precautions to avoid transferring the virus to their unborn child should they be positive.

The government together with some NGOs and private companies have started to give out ARVs to those in need of them. The roll out of ARVs has seen an increase in the numbers of people on ARVs. The number grew from 25 000 in 2005, to 100 000 at the end of 2007. This is estimated to be 38% of those in need of ARVs. The government has plans to continue to increase this number until everyone has access (ZNASP, 2006; Herald, 2007).

Despite national effort to educate people on the disease, HIV/AIDS-related stigma and discrimination are still high. People infected with and affected by the epidemic continue to be victimised by the society, suffer exclusion and are not accepted by others and various institutions. This discourages disclosure and limits the willingness of individuals to be tested for HIV/AIDS especially in situations where there is no access to ARVs (Avert, 2008a).

AIDS-related deaths in the adult population have resulted in a large number of OVCs creating an 'orphan pandemic' (UNGASS, 2008). By the end of 2007, there were more than 1.3 million orphans in the country. The 2005-2006 Demography and Health Survey (DHS) showed that 22% of children under the age of 15 years had lost at least one parent to HIV/AIDS while at least 160 000 children were estimated to have a chronically ill parent as a result of the virus (Singh et al, 2006).

“AIDS has left a huge cohort of orphans that threaten to overwhelm the existing support systems and the majority of these children will grow up impoverished, poorly educated, prone to criminal behaviour and disenchanted with society” (Population Development Review, 2001:622).

Some of these children are also HIV-positive and a greater number still, are at great risk of infection due to the lack of parental control and the need for comfort and sustenance (Kapp, 2004).

### **4.3 The government's response to the HIV/AIDS pandemic**

Since the early years of the HIV/AIDS problem, the government of Zimbabwe has tried to work with the available expertise and resources to gain knowledge about the disease and to control the epidemic. Since the first case of HIV/AIDS was recorded in the country, the government through the MoHCW, intensified the screening of all blood and related products to prevent infection through transfusions. At the same time, the government started a rigorous campaign to create public awareness of the disease. By 1987, the Ministry of Health was training its personnel in the different aspects of HIV/AIDS interventions. In 1989, the interventions expanded to include behaviour change campaigns and the prevention and treatment of STIs as well as establishing programmes for the care and support of PLWHA (ZNASP, 2006).

These interventions continued to be broadened and, in 1994, they included the mobilisation of non-health sectors to integrate HIV/AIDS in their programmes. By 1999, the government had embarked on a broad based multi-level consultative process that saw the establishment of the National AIDS Policy, the creation of the National AIDS Council (NAC) and the introduction of the National AIDS Trust Fund (NATF) popularly known as the AIDS levy. This is collected in the form of a 3% tax levy on all taxable income. This fund is managed by NAC. However, this council has been accused of misusing this AIDS levy. It has also been criticised for failure to consult with the relevant stakeholders and for poor coordination of programmes. The work of NAC is also constrained by inadequate financial and human resources as well as political interference (Gabus and Khumalo-Sakuthukwa, 2003).

The AIDS levy is a noble idea, but its impact undermined by inflation (Mpofu and Nyahoda, 2008). Furthermore, withstanding the harsh, current economic environment, the Zimbabwean government has increased its budget for health. This is in response to the growing demand on health services caused by the HIV/AIDS pandemic. Zimbabwe is committed to allocating 15% of its overall revenue to health in line with the Abuja Declaration 1988 (UNGASS, 2008).

In 2000, the national HIV/AIDS strategic framework for 2000 to 2004 was developed to operationalise the National AIDS Policy of 1999. The 2006 to 2010 Zimbabwe National Strategic Plan (ZNASP) replaced this. The 2000 to 2004 strategic framework includes human rights as part of the strategy against HIV/AIDS but the current plan does not, despite recognising that human rights violations and government policies have worsened the plight of PLWHA. This strategic plan is criticised for not outlining how the ambitious targets for 2010 will be achieved and also for its failure to either specify the duty bearers responsible for the implementation of the plans or offer a specific timeline for achievement (Kasambala, 2006).

In 2003, the government also declared HIV/AIDS a national emergency; this was extended until December 2008. In 2004, NAC took the position of Meaningful Involvement of People Living with HIV and AIDS (MIPA) in various programmes as both implementers and beneficiaries at all levels, in all key areas of prevention treatment, care and support (ZNASP, 2006). The government through the MoHCW started producing ARV drugs and rolling out a national PMTCT programme. The success of this intervention is largely credited with reducing the death rate of children under 5 years from 102 per 1000 infants in 1999 to 82 per 1000 in 2006 (Meldrum, 2008). The results of ARVs have also been positive, because of the high survival rate among patients. The survival rate was 91.1% in 2006 and increased to 93.1% in 2007 (UNGASS, 2008). One of the main goals of the government in the fight against HIV/AIDS is to ensure universal access to care and treatment.

#### **4.4 Prevention strategies used in Zimbabwe**

The primary prevention approach in use is articulated in the National Behaviour Change Strategy for 2006 to 2010 (NBCS). The purpose of this strategic plan is to guide programmes in the area of behaviour change. This is realised through an increase in the adoption of safer sexual behaviour, risk reduction and increased utilisation of HIV prevention services such as counselling, testing and PMTCT. This is in line with the government's goal to reduce HIV prevalence to less than 10% by the year 2010 in line with the Millennium Development Goals (UNGASS, 2008).

Five key strategies articulated in the NBCS are as follows:

#### ***4.4.1 Behaviour change (condom use, abstinence and faithfulness)***

The strategy focuses on behaviour change as the ‘cornerstone’ of any prevention strategy. This behaviour change is based on the ABC approach; on **A**bstinence, **B**eing faithful and correct and consistent **C**ondom use. Abstinence is targeted at young people who have not yet had any sexual encounter, thus delaying sexual debut. Faithfulness is encouraging for people in marriages and stable mutual relationships. Condom use, on the other hand, is mainly for the young who fail to abstain and adults who are in irregular and commercial sex relations (ZNASP, 2008). The ABC campaign has been applauded as one of the reasons for the decline in HIV/AIDS prevalence in the country.

In Zimbabwe, the consumption of condoms has increased significantly in both the public and private sectors. In 2004, over 45 million male condoms and about 353 600 female condoms were sold and distributed countrywide. In 2006, these numbers rose to about 980 560 female condoms and close to 55 million male condoms (UNGASS, 2008). The MoHCW distributes free condoms through the Zimbabwe National Family Planning Council (ZNFCP) and, at the same time, condoms are sold almost. Zimbabwe is hailed as one of the first African country to introduce the female condom (femmidom) in 1997. This was a positive step in attempting to increase the chances of women protecting themselves from STIs but generally this condom has been argued to be rather costly (US \$0.24) for the average woman compared to the male condom which is much more readily available free of charge. It has also been criticised for being difficult to use, unfamiliar and uncomfortable (Gabus and Khumalo-Sakuthukwa, 2003).

#### ***4.4.2 Education***

Part of the behaviour change strategy involves educating people about HIV/AIDS so that they know how to prevent, and live with, the disease. Current studies emanating from Zimbabwe, confirm that the majority of its population are well aware of the facts about HIV/AIDS; 75.5% of women and 81.3% of men are aware of the facts (UNGASS, 2008). However, research has shown that knowledge does not necessarily lead to behaviour change and therefore current programmes should be moving away from awareness to action. Furthermore, despite such high levels of knowledge, the majority of the population do not know their status (UNGASS, 2008; ZNASP, 2006).

Initial HIV/AIDS education focused on the adult population, but current education focuses on young adolescents, as they are increasingly being viewed as a high risk group. A number of adolescent sexual and reproductive health programmes have been developed for both in and out of school youth. These include community-based peer education, youth friendly health services, media programmes including a popular prime time television show (Studio 263), adverts, posters and school-based programmes. The Ministry of Education, Sports and Culture responded to the HIV/AIDS epidemic by introducing an HIV/AIDS life skills programme in schools. This is compulsory from fourth grade right up to tertiary education. Teachers are either trained to teach this during teacher training or through in-service programmes. Since 2006, more than 2750 teachers have been trained. However, despite these efforts, life skills education has not taken place consistently in schools (UNGASS, 2008; ZNASP, 2008).

#### ***4.4.3 Voluntary counselling and testing***

Another prevention strategy has been the encouragement of voluntary counseling and testing (VCT). Early testing allows people to know their HIV/AIDS status and to take positive action to protect themselves and their partners. A number of people have tended to get 'tested by proxy'. This is by assuming they are either HIV negative or positive based on the results of another person who they have been sexually intimate with. This is not always accurate considering that even long-term sexual partners can be discordant; this is where one partner tests HIV-positive while the other is negative.

The Zimbabwe AIDS Prevention and Support Organisation opened the first VCT centre in 1998. By 2001, the government, in conjunction with Population Services International and USAID, had launched 10 VCT centers throughout the country. The number of centers increased to 395 in 2005, and to 649 by the end of 2007 (Gabus and Khumalo-Sakuthukwa, 2003; UNGASS, 2008). While increasing the number of testing services is a priority for the government, especially in rural areas, so too is providing and maintaining high quality counseling services. VCT counseling has been hindered by a lack of trained counselors. PLWHA have also been encouraged to join in the counselor training programmes. To ensure larger numbers of people testing and knowing their HIV status, the government introduced the provider initiated testing in 2007 whereby any person

visiting a hospital, doctor or clinic is offered an HIV/AIDS test (Avert, 2008a). Thus while the test remains voluntary, service providers are now the ones who bring up the issue of conducting the test if the patient does not.

#### ***4.4.4 Blood and blood product screening***

HIV/AIDS prevention also includes blood and blood product screening. All blood for transfusions is screened for HIV. This process is managed by the National Blood Services of Zimbabwe (NBSZ). Zimbabwe was one of the first countries in the world to implement universal screening of blood of all voluntary, low-risk donors. Blood screening in Zimbabwe has been very successful, because HIV infection due to transfusions is next to nil (Gabus and Sakuthukwa-Khumalo, 2003; UNGASS, 2008; ZNASP, 2008). However, the number of units of blood being screened annually by NBSZ has declined steadily over the years, due to fewer clients donating blood; this has been attributed to HIV/AIDS awareness and infection (ZNASP, 2008).

#### ***4.4.5 Prevention of mother-to-child transmission***

Lastly, PMTCT has also been utilised in Zimbabwe. It was launched in 2002 and is coordinated by the MoHCW. It offers free voluntary counseling to pregnant mothers and free Nevirapine at the time of labor. The routine testing is offered at antenatal and family planning clinics. Government is committed to increasing the number of PMTCT services. Only 4% of women in need of PMTCT were receiving it in 2001 (Gabus and Khumalo-Sakutukwa, 2003). These services have grown from 205 in 2003 to 1422 by the end of 2006 (UNGASS, 2008). While this is a positive trend, it is still far from satisfactory. ZNASP (2008) explains that the government plans to target men in PMTCT service so that the service becomes more couple orientated. Currently, the programme is limited by a lack of funding and access to drugs (Rodriguez, 2008).

## **CHAPTER FIVE**

### **USING A HUMAN RIGHTS-BASED APPROACH IN ZIMBABWE**

Chapter five provides an outline of some of the challenges and merits of using human rights based approach given the current socio-political and economic context of Zimbabwe that was outlined in the previous chapter. It acknowledges that while it would not be easy to employ such a strategy, the benefits of doing so are significant.

#### **5.1 Background**

In Zimbabwe, the constitution contains a declaration of rights that articulates the rights and freedoms of the individual. This constitution also provides for the function of a dual legal system of General Law based on the Roman-Dutch law and African Customary law. There is no set hierarchy between these two but in cases where they conflict, statutory provisions specify the applicable regime (Zajkowski, 1998:25). In line with international and regional dynamics, the government has also ratified a number of agreements that seek to protect individual human rights. Some of these rights have become part of the law and others have influenced policy and practice.

#### **5.2 Debates on the use of rights in Zimbabwe**

##### ***5.2.1 Challenges***

Placing the discussion of health security, particularly vulnerability to HIV/AIDS, in a rights discourse, in a country like Zimbabwe has many challenges. These range from a government whose commitment to upholding rights is ambivalent; to strong religious and cultural sentiment opposing their use coupled with the lack of knowledge and the absence an enabling environment to encourage the use of rights. Like most countries, the adoption of rights has not been easy, the intensification of calls to realise rights saw the rise in political and religious conservatism accompanied resistance to their adoption (Population and Development Review, 2001).



The general acceptance of human rights in Africa has been a thorny issue, with some states violating these rights despite having ratified them.

“African states have historically lacked the legal culture, institutional infrastructure and political will to ensure the protection and promotion of human rights. Africa’s political history has been marked not only by a general neglect of the protection and promotion of human rights but also by active efforts by state organs to commit acts of repression and violence in contradiction of peoples entitlement to human rights” (Dersso, 2008:7).

Moreover, African leaders have largely shown a lack of political will in holding one another accountable for the violations of human rights. This is because of the history of the Organisation of African Unity (OAU), which was based on the doctrine of non-interference and emphasised state sovereignty. However, this concept of state sovereignty and independence is now being “used to stifle human rights protection by implying political apathy toward the abuse by African States of their own people” (Abbas, 2008:1).

African leaders have also in the past used the cultural relativist argument to resist changing policies and practices related to upholding human rights.

“They and other perpetrators of human rights abuse accused human rights defenders of neo-colonialism and labelled the very concept of human rights as western values” (Abbas, 2008:1).

Human rights values and their emphasis on individualism were considered un-African, going against the concept of communalism and therefore seen as violating and undermining fundamental cultural practices of the African people.

In Zimbabwe, some sections of the community still view rights as western influence, with negative consequences for those who embrace them. Chacha and Nyangena (2006:29) explain that while, “the truth is that, these rights are not the property of any one nation or culture, it is common knowledge that they have originated from the West”. Fortunately, this has changed somewhat due to the establishment of the African Human Rights Charter and the African Human Rights Court.

The cultural relativism debate tends to contradict the notion of human rights as universal, arguing that individual cultures tend to define their own values and ethics and these are not necessarily aligned to those upheld in the UDHR. Some of these cultures may have practices that are in conflict with human rights (Reichert, 2007). Applying human rights universally without consideration for specific cultural principles is argued to be a human rights violation in itself because it infringes on the nation's cultural identity.

Those in favour of the universality of human rights view the culture debate as an attempt to hide behind culture in order to allow the abuse of rights. As pointed out by Long, (2004:5), the "pursuit of rights should not be viewed as inimical to cultural and social values but as supporting people's healthy integration into culture". They argue that, everyone is equal and has the same rights by virtue of just being born a human being regardless of the culture they were born into (Donnelly, 1988). 'Culture talk' increasingly opposes itself to 'rights talk', with many debates continuing to revolve around what is culturally sanctioned and permissible (Long, 2004).

Zimbabwe is generally a patriarchal society and consequently women have fallen victim to this 'culture vs. rights' debate because of the subordinate roles that such a culture places them in. McFadden (2003:6) argues that, in Zimbabwe, as generally elsewhere in Africa, "women's sexual rights have been discussed within the parameters of cultural prescriptions about women's roles and bodies". A situation made worse by the fact that it is men who are the custodians of culture. They are the ones who make all the decisions (Human Rights Watch 2001:13). One interviewee<sup>10</sup> noted that "there is a reason why these rights are not talked about, man hate this right thing..." There was also a general consensus that the rights are not always applicable, in some situations one had to forget them. Another interviewee<sup>11</sup> explained:

...but as I was saying when you became married some of these rights don't work.  
If you start talking about rights, then you have to think if you still want your marriage, but anyway, you see most women don't even know most of these rights.

The lack of knowledge about rights and the picking and choosing of when and where to use rights impacts greatly on the ability of women to protect themselves. Individuals are caught between the demands of preserving their own social positions and then of their

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<sup>10</sup> Interview A

<sup>11</sup> Interview B

families. As a result they struggle against themselves, and against gender biased state policies to make decisions about their health (McFadden, 2006:3). It is clear from the study that decision-making for these women is a complex issue that goes beyond the rights that they have, but has more to do with the socio-economic context that they find themselves in. From the interviews<sup>12</sup>, it was clear that to a certain extent, men were also victims of their culture. In that, society places them under pressure to live up to cultural and peer expectations of a real man. Having multiple partners is one of the characteristic and this has negative consequences when it comes to the spread of HIV/AIDS.

Furthermore, Zimbabweans are generally not familiar with their individual rights. This means that they are not able to articulate them or to use them to protect themselves or to demand services that they are entitled to. There is need for programmes that educate people on rights so they can be embraced at an individual level (Petchesky, 1995). Moreover, for those in the know, there is a certain amount of discomfort at evoking human rights as a means of protection. These rights do not seem to fit well with the religious and socially acceptable behaviour. For a human rights-based approach to work not only should legal literacy be a priority, but these rights should be enforceable through a functional judiciary system (PACT, 1999). Interviewees<sup>13</sup> working in the human rights field emphasised the continued need for legal literacy and a functional judiciary system. Another interviewee<sup>14</sup> explained,

I think you can also talk about these rights when they are no laws to enforce them.  
In sexual rights you talk of the right to pleasurable sex, where do you report if you don't get it?

One went as far as to say that the only way out of the Zimbabwean crisis is “for the populous to demand their rights from the government” explaining that while NGOs can lobby the government to legislate certain instruments, if these are not useful to an ordinary person, then all their efforts are in vain. Even the women who were working in the field of human rights acknowledged that embracing rights was not easy. One interviewee<sup>15</sup> said,

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<sup>12</sup> Interview A, C and I

<sup>13</sup> Interview C, D and E

<sup>14</sup> Interview A

<sup>15</sup> Interview B

It's not easy to enforce these rights, culture plays an important role in the decisions that women make, so it depends on the individual strength of a woman and also on the knowledge she has.

More importantly, the constitution of Zimbabwe allows for the discrimination of women in situations recognised as customary or which fall within the parameters of family or personal law. Matters such as adoption, marriage and inheritance, for example, are in the ambit of personal law (Kasambala, 2006). Yet some of the prevailing cultural practices need to be re-evaluated in light of the HIV/AIDS pandemic. Examples of these are polygamy, paying bridal prices and widow inheritance.

Customary law allows a man to enter into more than one registered customary marriage, if he discloses the existence of prior marriages. Martinez et al. (1997) argue that in Zimbabwe, at least 19% of married women are in polygamous relations. However, it is not uncommon for a man to have a second family not known to his first family a concept known as keeping a 'small house' (Chingandu, n.d.). Women in such situations have to be making strategic decisions about how to behave and at times, this affects the choices they make concerning their sexual health. Women's decision-making capacity may be further compromised if they are also economically dependent on their spouse. Negotiating for safe sex becomes extremely difficult.

Balancing the respect of human rights and honouring culture is a huge challenge when one wants to apply a human rights-based approach to HIV/AIDS work. This is because culture is very important in ordering the lives of people, it provides continuity, consistency and creates social cohesion. It is much more important in times of strain, because it holds families and communities together, thus while human rights are important so too is culture (PACT, 1999).

Another challenge associated with using a human rights-based approach is that in Zimbabwe, ratifying international instruments does not automatically translate them into law. Therefore, the treaties cannot protect Zimbabwean citizens in the manner that they are supposed to be protected, because under Section 111B of the Constitution of Zimbabwe, these rights do not form part of the law, unless incorporated into the law as Acts of Parliament (Human Rights Watch, 2001). As a result, Zimbabwe is accused of

allowing the suppression of some human rights, particularly the rights of women and other minority groups because ratifying the conventions is just window dressing. Zimbabwe has failed to honour its international duties to protect its people according to the international treaties that it has ratified (Human Rights Watch, 2001; Zimbabwe Lawyers for Human Rights, 2006).

Using a rights-based approach is challenging in Zimbabwe, recent government policy and implementation has resulted in suppression of, and gross human rights violations (Kasambala, 2006). For example, the adoption of repressive legislation such as the Access to Information and Protection of Privacy Act (2002), which violates journalists' rights by requiring the registration of journalists and media houses and granting the state power to investigate journalists' sources of information. The Public Order and Security Act (2002), which outlaws gatherings of more than five people without police clearance, this ensures that the state has control of meetings held and can manage or even deny activities such as protests that are perceived to be anti-government. Such legislation has effectively curtailed the freedom of individuals to associate and express freely. NGOs working within the community have also had their work disrupted due to these policies. This points to a government that is not likely to accept an intervention that uses a human rights discourse.

Zimbabwe is also a predator state because of policies such as the land reform that were poorly implemented. During the land redistribution, white farmers were forcibly removed from their farms and workers believed to be against the redistribution assaulted. These acts of violence were perpetrated in most cases by the war veterans and people believed to be members of the ruling Zanu PF Party. Law enforcement agencies are reported to have done very little to end the violence and those who sought legal recourse did not get much relief. This land allocation also discriminated against female-headed households. Women were discriminated against because their rights to land as governed by customary law are weak (The Zimbabwe Human Rights NGO Forum, 2001b).

Zimbabwe's elections in 2002 and 2008 were also marred by serious acts of human rights violations (Human Rights Watch, 2008). Most of the violence was arguably state sponsored. It ranged from intimidation, curtailed freedom of speech, movement and

association, serious assault, abduction, arson, destruction of property, unlawful arrests and detentions as well as murder. Systematic abuse of women has also been documented; rape and sexual torture forming part of this abuse (Gabus and Khumalo-Sakutukwa, 2003). A weak judiciary system has meant that in cases of human rights abuse, those turning to the courts for redress have not found any. Judgements pertaining to such cases are reserved or delayed indefinitely (Human Rights Watch, 2008). This has caused much frustration for NGOs concerned with defending human rights, not only are they failing to get legal protection for their clients, but they themselves have become victims.<sup>16</sup>

Other policies and practices are also a threat to the rights of PLWHA. For example, Zimbabwe's health and welfare policies have resulted in the denial of access to healthcare for thousands of PLWHA needing immediate AIDS-related treatment. This is due to the extremely high cost of user fees for health services. While the government provides for a waiver of payment for those who cannot afford, a lack of clear information on the criteria about who is eligible, and failure to enforce this waiver have resulted in many failures to secure life saving treatments. These government initiatives have also been undermined by insufficient funds and a lack of human resource capacity (Kasambala, 2006).

Economic restrictions of informal trading put in place by the government also threaten the welfare of PLWHA in that they undermine their source of livelihood and income. Operation Restore Order disrupted the large informal economy that was thriving in the urban areas of Zimbabwe. The International Labour Organisation (ILO) estimated that in 2005, almost 4 million Zimbabweans earned their living through informal trading and supported over 5 million people (Kasambala, 2006). Most of these had their livelihoods disrupted due to Operation Murambatsvina.

The suppression of some rights by the state is also evident in the prejudice against citizens on the basis of their sexual orientation, which is widespread, and encouraged by the state. President Robert Mugabe, in a speech in 1995, stated that he "believed that homosexuals have no rights at all" and then in 1996 at a Heroes Day Celebration he described homosexuals as "worse than dogs and pigs" (Human Rights Monitor, 2004:2).

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<sup>16</sup> Interview H

This is a violation of the rights of gay and lesbian people to freely choose their partners and experience a satisfying and pleasurable sexual life. “This onslaught has devastating effects on public health as essential measures to prevent HIV/AIDS are scrapped in the name of morals and as vulnerable people are driven in the shadows” Long (2004:3).

One interview<sup>17</sup> participant who works for an NGO that is lobbying the government for a new constitution explained that one of the intended changes to the new constitution would be to ensure the rights of sexual minorities. “Despite there being no Act of Parliament or statute that makes homosexuality illegal it is criminalised under Common Law, which is the unwritten law based on general custom” (Human Rights Watch, 2001:29). Being gay is believed to be un-African, western behaviour that has contaminated Zimbabwe’s culture. The absence of any law to protect this group sets the stage for their abuse. Zimbabwe does not have any specific programmes targeting gay people. Other groups of people that do not have any legal status in Zimbabwe are IDUs and commercial sex workers (UNGASS, 2008).

The government of Zimbabwe has also turned against NGOs that work in the fields of human rights and democracy. Other western sponsored organisations have also been targeted. The government has threatened to pass legislature that allows it to monitor and interfere with the work of NGOs to ensure that it is aligned to their political agenda. This repressive political environment prevents activism and debate on HIV/AIDS among civil society and PLWHA. Recently the government lifted a ban on the operations of some NGOs that it had imposed in the run up to the March 2008 elections (Kasambala, 2006; PlusNews, 2008a). Consequently, mobilising for any activity is now a risk in Zimbabwe. There is always the danger of the activity being perceived as a political gathering. Another problem is that society is now largely divided along political lines and therefore a challenge to bring together people from the opposing parties together for any issue (Human Rights Watch, 2008). Another research participant who works for an organisation concerned with legal aid and advocacy for women’s rights explained a major challenge to their work is that, “the environment is heavily polarised along party lines making lobbying and advocacy for women’s rights secondary”<sup>18</sup>

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<sup>17</sup> Interview F

<sup>18</sup> Interview B

However, any rights discourse that fails to take into account the complex socio-economic factors that impact on people's decision-making process on a daily basis is inadequate. Being aware of one's rights is not protection in itself, especially without other measures to ensure the improvement of the marginalised states of the poor and minority groups. Such marginalisation prevents them from protecting themselves. Petchesky (1995) argues that reallocation of resources is vital and this is precisely what second-generation rights are about. For example, a woman who is economically dependent on her husband for her and her children's survival will be limited in her ability to make decisions that may antagonise her husband, and this will include decisions about her sexual well-being.

The government of Zimbabwe acknowledges the importance of socio-economic security in HIV/AIDS management. This is why it has adopted macro economic policies that are aimed at mitigating the effects of HIV/AIDS. These include the National Economic Development Priority Programme 2005-2006 (NEDPP) aimed at the reduction of inflation, stabilisation of the currency and ensuring food security (UNGASS, 2008). Unfortunately, this policy has not achieved much as inflation continues to soar, the Zimbabwean dollar is virtually useless and the majority of the population is getting poorer by the day.

Lastly, the use of a developmental approach that encourages upholding second generation rights is frustrated by the subordinate state of these rights to first generation rights. Most people automatically associate human rights with civil and political liberties and not economic and social freedoms. This is true even in HIV/AIDS management because in most instances where human rights have been evoked, the discussions have focused on protecting first generation rights. For example, issues of non-discrimination in workplaces, rights to privacy in testing and disclosure as well as issues of informed consent. However, as noted by PACT (1999:35) "There is increasing recognition among development practioners that unless these social and economic factors are addressed HIV/AIDS will rage on reversing hard won developmental gains".



In the interviews<sup>19</sup>, the place of second generation rights was clear. Ideally they are just as important as first generation rights but in practice, this is not always true. Yet in a climate such as Zimbabwe, second generation rights are now more important than ever. One interviewee<sup>20</sup> explained that one cannot separate these rights because “they work collectively and separately to create a dignified and free human being”. They are all equally important. Another interviewee<sup>21</sup> who works with victims of torture and political violence felt that from the work that they are doing, it is becoming increasingly clear that socio-economic rights are becoming more and more important to their clients than the political and civil liberties that they aim to defend.” The struggle for food and health care is at the forefront of the lives of ordinary Zimbabweans.

### ***5.2.2 The importance of a human rights-based approach to HIV/AIDS prevention***

The right-based approach to HIV/AIDS management provides a basis for a paradigm shift for understanding the HIV/AIDS epidemic. Instead of engaging with HIV/AIDS as an individual problem, it is viewed as a social problem, which can affect different sections of the population, shifting the understanding of HIV/AIDS from a behavioural to a material perspective. It is no longer about the types of behaviours that people engage in, that lead to infection but more about what it is that people lack that predispose them to infection (Aniekwu, 2002).

From the interviews<sup>22</sup>, it was clear that such a shift in perspective is profound in addressing the various challenges that HIV/AIDS presents. At an individual level, it allows for a greater chance of acceptance rather than denial because it is no longer about what you have done, that has made you sick, but the problem now lies in your environment. At a community level, it discourages stigma and discrimination because everyone is at risk. Interviewees<sup>23</sup> from HIV/AIDS organisations spoke about the problem of stigma faced by HIV/AIDS patients. As a result, they immediately recognised the benefits of such a paradigm shift.

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<sup>19</sup> Interview C, I and K

<sup>20</sup> Interview C

<sup>21</sup> Interview C

<sup>22</sup> Interview B, J, and L

<sup>23</sup> Interviews G, H, I, J, K and L

As noted by Gupta and Weiss (1993:1) “The way we define a problem determines how we approach its solution.” If we continue to think of HIV/AIDS as just a sexual problem caused by the way people behave and not interrogate why they behave the way they do or why they fail to behave in the desired way, we will be fighting a losing battle. When we look at the problem with a broader perspective, then our solutions will not only target individual behaviour change, but will address the social, economic and technical imbalances that limit behaviour change.

Therefore, a human rights-based approach would empower an infected individual to fulfil immediate needs, by demanding their rights as a matter of entitlement and not as an act of kindness or charity. Right holders are empowered to assert their rights thereby reducing risk and increasing the ability to cope with HIV/AIDS (UNAIDS, 2005:9). In Zimbabwe, people have failed to get adequate health services because of high user fees for accessing health. Yet, if they knew that it is their right to get those health services and that it is the duty of the state to provide the services then they would be bolder insofar as demanding such services. Health in Zimbabwe is identified as a ‘right’. Health services are viewed as a necessary and primary condition of development. The aim of the government is to ensure health access regardless of the ability of people to pay (Kasambala, 2006). One interviewee<sup>24</sup> explained that when it comes to ARVs, patients are sometimes not sure where to go for treatment or how to demand this service.

At the same time, this rights-based approach compels the relevant duty bearer to deliver services or goods that the individual is entitled. This is because the duty bearer is clearly identifiable. In this case, the government is the primary duty bearer. Once a duty bearer is identified, then they can be petitioned to provide adequate service that the individual is entitled to. Accountability is also ensured when using a rights-based approach. Duty bearers are answerable for their failure to protect human rights. They must comply with the international instruments that they have ratified (UNAIDS, 2005).

Such an approach would also be useful in cultivating a culture of the protection of rights so that the rights of PLWHA can be entrenched. This is because the rights-based approach will encourage people to respect each other’s rights and educate people to

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<sup>24</sup> Interview K

overcome their fears, ignorance and prejudice that lead them to abuse the rights of others or even allow the abuse of their own (Democracy Consolidated Programme, 2007). This approach would therefore set a tone that would encourage the recognition of all human rights even those not relating to health and HIV/AIDS, this is because human rights are by nature indivisible and interdependent, you cannot effectively uphold one while undermining another.

The human rights-based approach also provides links with other social movements that use the same language of rights, for example, the women's movement, the gay and lesbian groups and children's rights groups. This can lead to the formation of allies of convenience that can collate to fight for a common agenda. When marginalised people form collective groups to mobilise around a common problem this soldered the links between them and gives them a firmer voice. HIV/AIDS is a problem that affects all these groups and can therefore become a relaying point for them all (Long, 1999; Petchesky, 1995).

Human rights law, on which this approach is based, helps states to respond appropriately to the challenges of HIV/AIDS epidemic by providing a legally binding framework on which they can formulate laws and policies that interrogate public health objectives and adhere to human rights standards. Programmes and policies are argued to be most effective when they are based on the normative framework of international rights. They provide a foundation that has well established procedural, institutional and other accountability mechanism to address and implement social change.

WHO claims that "the design and implementation of health care policies can either improve or worsen human rights; nations must ensure that their health care programmes are free from discrimination, readily accessible, respectful of medical ethics and of good quality" (Egendorf, 2003:32). Basing policies on human rights will go a long way in ensuring that such goals are achieved.

International treaties and laws, on which human rights-based approaches originate, are useful because they place a legal obligation on the government to uphold them and this can be challenged at an international level. When a human rights framework is used,

violations, particularly those in which the state is involved can be taken up to regional and international bodies, which permit such complaints. This of course has to happen once all domestic remedies have failed or proved to be ineffective (Hassim et al., 2007).

A human rights framework also provides a legal framework for advocacy in the fight against HIV/AIDS. Advocacy is probably the most common link between human rights and HIV/AIDS. Advocacy groups research and document issues, and then denounce the abuse of human rights (Roseman and Gruskin, 2004). NGOS and advocacy groups are also able to monitor the performance of states in their policies and health programme and to take action for redress when public health policies violate human rights standards (Aniekwu, 2002; Patterson and London, 2002).

Zimbabweans can also benefit from the fact that the government has ratified various conventions pertaining to human rights even when these do not form part of the laws of the country. With the help of lobby groups such as NGOs and other activist movements, these conventions can be used as frameworks and guidelines to push for better opportunities for the marginalised. The government can be challenged to amend the constitution to include the conventions and protocols that they have ratified. Through such lobbying the government will be required to increase access to information and reform legislation in order to implement laws that protect every citizen and ensure the guaranteeing of means of redress for the violation of these rights (Kasambala, 2006).

Furthermore, the conventions can be employed by the relevant stakeholders to make submissions on draft legislation, aimed at protecting marginalised groups in cases where such laws have been absent. They can also encourage the repealing of laws that undermine the ability of some groups to protect themselves through lobbying for changes to pre-existing laws (Hassim et al., 2007).

Moreover, the use of a rights discourse allow for the dissemination of information and provision of services to everyone without discrimination based on age, sexual orientation or even marital status because these rights are meant to protect everyone. This is because human rights encourage access to up-to-date, relevant and correct information. This encourages general HIV/AIDS awareness campaigns and rights education. The

population becomes more conscious with regard to identifying human rights violations and takes appropriate action to protect themselves from disease. Everyone has the right to seek, receive and impart all types of information (UNGASS, 2008 and USAID, 2008). Accurate information encourages people to make informed choices. Adolescents, women, prisoners, gay people and sex workers can all access life saving information because they are entitled to it.

Additionally a rights-based approach is premised on the self-interest of the individual. It focuses on the benefits that it provides for the individual without looking at the issue from the perspective of the partner, community or society. This works well for those lacking individual autonomy, such as women in patriarchal societies. Without this autonomy, they are under enormous pressure to comply with prevailing gender and reproductive norms and thus will act based on custom and traditions of the society they live in (Markus, 1996). While this is a selfish and individualistic approach, it can be life saving.

Furthermore, a rights-based approach to HIV/AIDS management would also help to bring the HIV/AIDS epidemic back into the limelight in a country such as Zimbabwe. People who lack resources for basic survival such as food, shelter, healthcare, clothing and education will not view HIV/AIDS as a priority issue. It is just one of the many other problems that make their lives very difficult and does not pose an immediate danger. HIV/AIDS cannot be stopped unless and until issues such as gender inequality, poverty, sexual empowerment and effective legislature are taken care of (UNAIDS, 2008). In other words, once second-generation rights are met and people have what they need for basic survival only then will they have the luxury of looking at the other threats to their survival.

Focusing on upholding second-generation rights is important because it leads to an improved quality of life for the population. This is because they are concerned with the social welfare of individuals, seeking to create a context, free from poverty, powerlessness, ill health, homelessness and shortages of basic infrastructure for a satisfactory life. Therefore, in order to be effective, HIV/AIDS interventions also economically empower those without financial security, ensure social service provision

by the government and lead to legislation that protects those who are currently being victimised in one way or the other.

However, these programmes also need to be monitored to ensure that they do not end up helping to perpetuating pre-existing and problematic stereotypes that work against meaningful progress in the fight against HIV/AIDS. Or minimise those factors that make some groups more vulnerable to HIV infection. For example, programmes that target women only in an attempt to stop the transmission of disease from mother-to-child may in fact reinforce the idea that women are not the vectors of the disease but are responsible for the care and wellbeing of children and men are not involved. Other income-generating initiatives simply ensure that men have more access to cash and do not benefit the whole family. They just give men more spending power (UNAIDS 2008).

### **5.3 The success of a human rights paradigm**

#### ***5.3.1 The gains***

Already, human rights activists have achieved much in the HIV/AIDS battle including the right to non-discrimination based on one's HIV status. Initially, when the disease was identified, many PLWHA lost their jobs and were denied essential services such as insurance and funeral cover leading to loss of life for some. In Zimbabwe, due to the introduction of policies such as the Labour relations statutory Instrument, PHLWA are now protected from discrimination (UNGASS, 2008). In the interviews<sup>25</sup> conducted, this was one of the most widely discussed achievements of a human rights-based approach in the fight against HIV/AIDS. It was argued to have encouraged a number of organisations to formulate HIV/AIDS policies.

Human rights-based approaches have also lead to the realisation of the right to treatment as part of essential healthcare. It seeks to ensure equitable and non-discriminatory access to health service for all including PLWHA. Non-discrimination would be assured irrespective of age, marital status, sexuality, gender or class, because human rights discourse are shaped by universality of rights (Kasambala, 2006:6).While healthcare provision has generally crumbled in Zimbabwe, the government with the help of various

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<sup>25</sup> Interview B, C, G, J, K and L

NGOs has tried to provide free ARVs to those in need to achieve universal access. However, this has been undermined by shortages of foreign currency and hyperinflation. The possibility of getting treatment upon diagnosis was viewed by one interviewee<sup>26</sup> as a possible reason for the increase in the number of people taking HIV/AIDS tests. This approach would mean a rise in the standard of welfare services and protection from all disease, not just HIV/AIDS.

The government, through its multi-sectoral approach, has also tried to ensure the rights of PLWHA to participate in the development of HIV/AIDS policies. A rights-based approach encourages the meaningful participation of PLWHA and other vulnerable groups in decision-making and monitoring of HIV/AIDS-related programmes (Kasambala, 2006). Essentially a human rights-based approach is based on participation, inclusion and empowerment of every person, especially the marginalised groups that have entered the HIV/AIDS battle as members of already oppressed groups (USAID 2008). AIDS organisations interviewed<sup>27</sup> explained the importance placed by the government on high involvement of PHLWA in programme formulation and implementation.

In Zimbabwe, the National Policy on HIV/AIDS upholds the dignity and human rights of people and prohibits discrimination against them and testing without consent (Kasambala, 2006). Consent in testing and notification have also been hailed as one of the successes of a human rights paradigm. Yet, at the same time, human rights activists have been accused of preventing or undermining the importance of widespread testing to ensure early detection of HIV/AIDS because of their over emphasis of consent, counselling and confidentiality. Human rights activists counter argue that it is possible to increase HIV/AIDS testing without sacrificing consent, counselling and confidentiality. It is much easier to gain access to people when they are assured of confidentiality. Fear of stigmatisation is what prevents people from getting tested (Cohen and Jurgens, 2007).

Examples of successful human rights-based approaches to HIV/AIDS management can also be drawn from the successes achieved in other countries. These include Brazil's

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<sup>26</sup> Interview H

<sup>27</sup> Interview G, H and I

controversial decision to either allow the local, generic manufacture of patented drugs, particularly ARVs, or have them produced at a cheaper cost so that the public could afford them. This was in recognition of the states duty to provide drugs for everyone (Patterson and London, 2002). Consequently, Brazil is recognised as a country that has placed human rights at the centre of their HIV/AIDS response.

In South Africa, the Treatment Action Campaign (TAC) has successfully challenged the government on access to treatment using a rights-based approach. For example, they have argued that the South African government should change its policy to provide resources to ensure PMTCT of HIV/AIDS because failure to do this would be a breach of South Africa's international legal obligations (Patterson and London, 2002).

Similarly, in Venezuela in 1999, the Supreme Court ruled that the government, by failing to provide adequate prevention and treatment services, was in violation of the right to life, health and access to scientific advances all of which were guaranteed by the country's constitution. As a result, the state was ordered to provide free ARVs and treat opportunistic infections for all PLWHA. In Namibia, the AIDS Law Unit has also used the human rights-based approach to pressure the government to ensure access to treatment (Roseman and Gruskin, 2004).

In the Philippines, human rights advocates and various NGOs pressured the government to honour its international obligations to protect the rights of vulnerable groups. This led to the passing of an act that prohibited mandatory testing and discrimination on the basis of one's HIV/AIDS status on the provision of employment, healthcare, travel, credit and insurance (Roseman and Gruskin, 2004).

Embracing a human right approach in a country like Zimbabwe therefore has long-term benefits for the population. Such benefits would be more beneficial when integrated with the behaviour change approach. This integrated approach would create enabling environments that prevent individuals from indulging in risky sexual behaviour for economic gain because their basic needs are catered for by the government, discouraging stigmatisation of the sick and isolation of their families because it proposes an alternative way of understanding the spread of HIV/AIDS. This approach would also encourage



people to get correct and adequate information regarding their health and influence the formulation of policy and laws so that they are more protective of and beneficial to the individual.

## **CHAPTER SIX**

### **CONCLUSION**

This research has shown that the HIV/AIDS pandemic is a serious problem in Zimbabwe. The interviews conducted and the literature reviewed both show that HIV/AIDS has killed thousands of people, caused many children to be orphaned, hampered economic development, disrupted family life and put pressure on health infrastructure. To date, there is no cure for HIV/AIDS and therefore prevention continues to be the mainstay of the fight to control the pandemic. In Zimbabwe, prevention strategies are based on the National Behaviour Change Strategy. While this approach has resulted in a decline in HIV/AIDS prevalence, the levels of HIV/AIDS remain very high. One in five adults is currently living with the disease. The current socio-political and economic conditions were discussed as a threat to the decline in HIV/AIDS prevalence and recognised as having the potential to reverse the gains of the behaviour change approach to HIV/AIDS management.

Behaviour change strategies are argued to be an inadequate method of managing the HIV/AIDS epidemic because they do not empower people to change, yet place the burden of change on the individuals self efficacy. They neglect the importance of the environment in shaping the behaviour of individuals. Individual agency is constrained by structural forces which, if not addressed, derail any attempts to change. In Zimbabwe, religion, traditional custom, the law, poverty, inflation, political instability and natural disasters all converge to create conditions that limit the ability of individuals to behave as they know they should in order to prevent HIV/AIDS infection. This paper therefore proposes the use of a developmental approach which encourages a deeper understanding of society through an analysis of the historical context and the kinds of social, economic and political barriers that impede people from effectively managing the disease and providing solution that are tailor-made for the group and developed with the meaningful participation of all stakeholders (UNAIDS, 2008).

This research sought to explore the possibilities of upholding second generation rights as a long-term measure that would complement the behaviour change approach in HIV/AIDS prevention. The current social, political and economic situation in Zimbabwe has deteriorated to an extent that the vast majority of people are facing starvation and do not have enough resources to ensure access to healthcare, education and water, among other issues. In light of this situation, a human rights-based approach was chosen as the best practice for HIV/AIDS management, because second generation rights are concerned with ensuring an adequate standard of life sufficient for health and wellbeing. This standard of life is guaranteed in the provision of adequate food, clothing, shelter, medical care and other social services.

Due to the crisis that Zimbabwe is experiencing, second generation rights have been undermined and dangerous survival strategies are now common. The lives of ordinary Zimbabweans have been disrupted to the extent that they now have to act in ways that they are not accustomed to in order to meet their day-to-day survival needs. This includes anti-social behaviour such as illegal black market trading, petty crimes such as theft, domestic violence fuelled by frustration and survival sex. Some of these new modes of behaviour have undermined pre-existing behaviour change programmes aimed at preventing HIV/AIDS. People's behaviour is changing and sometimes for the worse. It is therefore a necessity that approaches for mitigation must change. A stable environment needs to be created and this is what second generation rights seek to achieve. Integrating behaviour change strategies with the a human rights based approach would therefore be useful in consolidating the gains achieved so far in the HIV/AIDS battle and ensure a further decline in HIV/AIDS prevalence. It would create a context that allows individuals to change their sexual behaviour and maintain these changes so that they protect not only themselves but also their partners and offspring from HIV infection.

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## Appendix A

### Key Informant Interviews: Personal Information

Name and Surname.....

Field of Expertise: HIV/AIDS ☐ Human Rights ☐

Name of Organization.....

Job Title .....

Can your name be quoted in this research? Yes ☐ No ☐

Can the name of your organization be quoted in this research? Yes ☐ No ☐

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### Consent and Confidentiality Agreement

I ..... agree to participate in this research project entitled Fighting HIV/AIDS insecurities: A human Rights Based Approach. The research is being conducted by Patience Mungwari, in partial fulfillment for a Masters Degree in HIV/AIDS (Mphil HIV/AIDS and Society) University of Cape Town

I understand that this will be done through an interview. Which will be audio taped.

I understand that the information gathered is confidential and will be used only for the purpose of the above mentioned study.

I understand that all the information I give will be kept confidential to the extent permitted by law, and that the names of all the people in the study shall be kept confidential unless agreed otherwise.

I understand that because of the study there could be violations of my privacy. To prevent violations of my own and others' privacy, I have been asked not to talk about any of my own or others' private experiences that I would consider to be too personal or revealing.

I understand that I will not receive any direct benefit from participating in this study.

I have read and understand this information and I agree to take part in the study.

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Date

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Your Signature